West Baltimore
Primary Care Access Assessment & Strategic Planning Project

FINAL REPORT

June 2012

Submitted to:

The Mid-Atlantic Association of Community Health Centers

Submitted By:

John Snow Inc.
44 Farnsworth Street, 7th Floor
Boston, MA 02210

PREFACE

This report summarizes findings and recommendations from a West Baltimore Primary Care Access Assessment & Strategic Planning Project, conducted by John Snow Inc. (JSI) between May 2011 and January 2012. The project was funded by Kaiser Permanente under the oversight and administration of the Mid-Atlantic Association of Community Health Centers. The project was initially conceived and called for at the culmination of the West Baltimore Health Care Summit that was held in 2010 and was led by a Steering Committee composed of key public health and community health stakeholders from West Baltimore. The Steering Committee was spearheaded by Senator Verna Jones-Rodwell (Maryland General Assembly Member), Samuel Ross, MD, MS (CEO of Bon Secours Baltimore Health System), and Miguel McGinnis (CEO of the Mid-Atlantic Association of Community Health Centers) who worked in close concert with John Snow, Inc. and served as the liaison between JSI and the Steering Committee.

The goals of the assessment were to: (1) identify the most pressing community health needs of the West Baltimore area, (2) assess the overall strength of the primary care safety net, and (3) develop recommendations regarding the realm of possible action that should be taken to expand access and strengthen the area's safety net system. The underlying premise for this project was to explore the steps that the area's public and private safety net providers, in collaboration with other community stakeholders, should take to ensure that the safety net is fully prepared to take advantage of the opportunities provided by Affordable Care Act as it unfolds over the next 2-3 years. More specifically, JSI was charged with: 1) compiling existing quantitative data to determine primary care capacity and major community health needs, 2) conducting key informant interviews, 3) conducting a community survey of residents, 4) facilitating a series of stakeholder retreats to obtain community input and ensure on-going involvement of the area's leading safety net stakeholders, and 5) developing a series of reports and presentations to communicate the project's findings and recommendations.

Overview of John Snow, Inc. (JSI)

John Snow, Inc. (JSI) is a health care research and consulting organization committed to improving the health of communities throughout the United States and overseas. Throughout its 35-year history, JSI has worked to address the needs of underserved populations to improve access and the quality of health care delivery systems. JSI fully shares the Steering Committee for this project's mission to expand access to high quality health care services to low-income, uninsured residents of the West Baltimore area and were honored to be involved in this assessment. The Project Team for this effort was led by Alec McKinney, Senior Project Director with JSI's U.S. consulting and research division. Natalie Truesdell, Senior Analyst at JSI, also played a major role and was involved in all aspects of the project. Also participating from JSI were Karen Schneider, PhD, (Senior Analyst) and David Landy (Research Analyst/Research Assistant).

Acknowledgements

This project was conducted with the support of the Mid-Atlantic Association of Community Health Centers and was guided by a Steering Committee (listed below) made up of community leaders from West Baltimore. Additional input was provided by a stakeholder group (listed below) composed of the core of the West Baltimore health care safety net. Their combined expertise, knowledge, and commitment to the project were vital and this project would not have been possible without their support and guidance. During this project JSI interviewed dozens of individuals. First, JSI interviewed administrative and clinical staff members from core safety net providers that serve West Baltimore. Second, JSI interviewed other key stakeholders including representatives from other health and social service providers, public officials, elected officials, community-based advocacy groups, and consumers of care. JSI also conducted a survey of nearly 300 residents to gain better understanding of their care seeking preferences, the barriers to care they face, and their experience accessing primary care services. JSI would like to acknowledge the support of all of the people that were involved in this project, particularly those who were interviewed and surveyed, as well as those who participated in the project's Steering Committee and stakeholder meetings.

TABLE OF CONTENTS

- BRFSS Graphs
- Survey Results

- Key Informants and Stakeholders
  - West Baltimore Key Informant Interviews List
  - West Baltimore Stakeholders List
- Health Reform
  - "The Affordable Care Act in the State of Maryland: Foundations and Opportunities for Reform"
  - "Maryland's Health Benefit Exchange"
- Other Project Materials
  - West Baltimore Maps
  - West Baltimore Evidence Based Intervention Examples
  - Baltimore FQHC Clinic Locations and Times
  - Phase I Meeting Slides (Oct 26)
  - Community Stakeholder Presentation (Dec 9)
  - Stakeholder Retreat Presentation (Feb 13)
  - Project Timeline

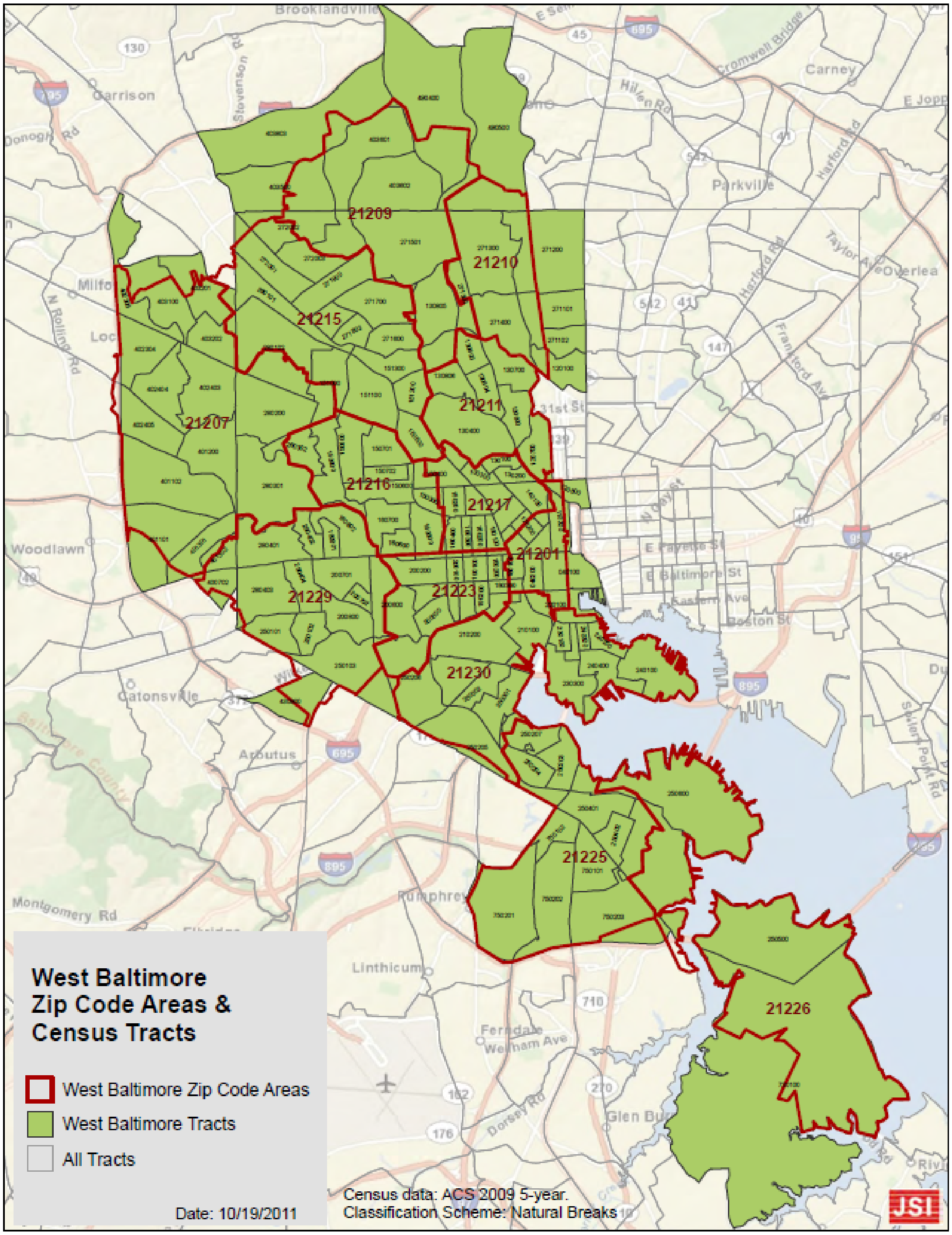
I. INTRODUCTION & BACKGROUND

In January 2010, Senator Verna Jones-Rodwell, in collaboration with Bon Secours Baltimore Health System, convened a group of over 100 leading stakeholders to participate in a West Baltimore Health Care Summit focusing on improving health status and access to health care services in the West Baltimore area. Based on the findings from the Primary Care Access Workgroup, under the leadership of Miguel McInnis, CEO of MACHC, and the participation of health center leaders, hospital executives, and community participants, it was ultimately determined that a comprehensive assessment should be conducted to better understand the health related needs of West Baltimore residents and assess the capacity and strength of West Baltimore's safety net.

As a result, in May 2011, John Snow Inc. (JSI) a leading public health research and consulting firm, specializing in the dynamics of safety net systems, was hired by the Mid-Atlantic Association of Community Health Centers (MACHC) to implement a West Baltimore Primary Care Access Assessment & Strategic Planning Project. The project was funded by Kaiser Permanente under the oversight and administration of MACHC and a Steering Committee made up of community leaders from West Baltimore. The goals of the effort were to: (1) identify the most pressing community health needs of the West Baltimore area, (2) assess the overall strength of the primary care safety net, and (3) develop recommendations regarding the realm of possible action that should be taken to expand access and strengthen the area's safety net system. The underlying premise for this project was to explore the steps that the area's public and private safety net providers, in collaboration with other community stakeholders, should take to ensure that the safety net is fully prepared to take advantage of the opportunities provided by Affordable Care Act as it unfolds over the next 2-3 years. More specifically, JSI was charged with: 1) compiling existing quantitative data to determine major community health needs and primary care capacity, 2) conducting key informant or stakeholder interviews, 3) conducting a community survey of residents, 4) facilitating a series of stakeholder retreats to obtain community input and help ensure on-going involvement of the area's leading safety net stakeholders, and 5) developing a series of reports and presentations to summarize and communicate the project's findings and recommendations.

For this assessment and planning project, West Baltimore was defined very broadly to include nine (9) zip codes that collectively make up the entire west portion of Baltimore, spanning from 21209 in the northwest portion of the City up to 21226 in the southeast portion of the City. Specifically, the zip codes included in the project were 21201, 21211, 21215, 21216, 21217, 21223, 21225, 21229, 21230[1].

[1] When possible data was collected at the zipcode level, however some data sources were available only at the citywide level.


West Baltimore
Zip Code Areas &
Census Tracts
West Baltimore Zip Code Areas
West Baltimore Tracts
All Tracts
Date: 10/19/2011
Census data: ACS 2009 5-year.
Classification Scheme: Natural Breaks
21209
21210
21215
21211
21207
21216
21217
21201
21223
21229
21230
21225
21226

II. ASSESSMENT AND STRATEGIC PLANNING APPROACH AND METHODS

To conduct this assessment and strategic planning project, JSI implemented a three-phased approach organized around a series of Steering Committee and Stakeholder Group Retreats. This approach allowed the JSI project team to gather an exhaustive array of quantitative and qualitative data, vet the information gathered with the Steering Committee and Stakeholder Groups, and explore issues related to community need, safety net strength/capacity, and strategic responses. JSI has found in previous work that a phased approach of this nature encourages a thoughtful, iterative discussion that promotes concrete final recommendations and solid buy-in among participants. The ultimate goal of this project was not to collect and present data related to need and safety net capacity but rather to facilitate buy-in regarding a series of strategic ideas that could be implemented through collaborative action by the safety net.

In Phase I, the JSI Project Team collected and reviewed data from existing federal, state, and local data sources including data from the US Census Bureau, the Centers for Disease Control and Prevention, The Health Resources and Services Administration, the Maryland Department of Health and Mental Hygiene, the Maryland Health Services Cost Review Commission, the Maryland Medicaid Program, and the Baltimore City Health Department. The bulk of our data collection efforts are compiled in a Project Databook that has been included with this report. Phase I interviews of a broad cross section of key health care stakeholders from West Baltimore obtained qualitative information regarding the needs of the community, existing service gaps, and barriers to access. These interviews explored the strengths and weaknesses of the West Baltimore safety net system and began to collect ideas on how the safety net should respond to address the issues identified. A list of the people who were interviewed is included in Appendix A. Finally, in Phase I the Project Team collected information to clarify the potential impacts of the Patient Protection and Affordable Care Act (PPACA) on West Baltimore's residents and its safety net. Information was collected from a variety of sources including the Maryland Health Care Reform Coordinating Council, the Maryland Health Services Cost Review Commission, Kaiser Family Foundation, the Commonwealth Fund, and Johns Hopkins Bloomberg School of Public Health. This analysis was also informed by JSI's work in Massachusetts with the Blue Cross Blue Shield Foundation of Massachusetts, which explored the impacts and outcomes of Massachusetts' health reform efforts over the past 5-years. At the end of Phase I, the JSI Project Team convened the project's Steering Committee Meeting to present its initial findings, explore their implications, and begin to frame the strategic process moving forward.

In Phase II, the project team completed its secondary data collection efforts but its main focus was on compiling primary data directly from the target population in West Baltimore through a community

survey. More specifically, the Project Team gathered data using a 5-page, 28-question survey that collected information on health care needs and barriers to access as well as consumer attitudes and behaviors regarding how those from West Baltimore preferred to and actually did access primary care services. The project team collected more than300 surveys at health fairs, farmers markets, and other community venues over a series of three visits to the area. A copy of the survey is included in Appendix B and its findings are summarized in the Project Databook. At the end of Phase II, the JSI Project Team convened the first of two Stakeholder Retreats to present its integrated findings and begin discussions regarding possible strategic ideas for addressing community need and the underlying access-related issues in West Baltimore.

In Phase III, the Project Team continued to integrate the range of quantitative and qualitative data collected throughout the project, including data provided by the Maryland Medicaid Program. This data was obtained and analyzed with significant support from the Hilltop Institute at the University of Maryland and was instrumental in the project's efforts to characterize and understand the impact of the wide range of providers that are part of the primary care safety net West Baltimore. The bulk of the Project Team's Phase III efforts were to prepare for the final Stakeholder Group Retreat. The Project Team developed a presentation summarizing its finding and in based on these findings compiled a summary compendium of a range of best practice programs that could be applied in West Baltimore to improve health status , expand access, and promote better engagement in care. The goals of the final retreat were to present our final findings, agree on a set of community health priorities, and develop initial buy-in on strategic ideas for addressing the priorities identified by the group, particularly in light of PPACA and pending health care reform.

III. SUMMARY FINDINGS BY TOPIC AREA

The breadth of quantitative and qualitative data that was compiled and analyzed as part of this strategic planning project was considerable. The following is a bulleted summary of some of the key findings from our research. Additional information can be found in the Steering Committee and Stakeholder presentations included in Appendix X as well as the Project Databook.

A. ACCESS TO CARE / EXISTING CAPACITY

Strengths

- **Strong Informal Network of Safety Net Providers.** West Baltimore's safety net, those who predominantly serve low income, underserved populations, is extremely large and dispersed. According to data collected by the Hilltop Institute it is comprised of more than 10,000 providers that collectively billed for more than 250,000 unduplicated claims on behalf of more than 66,000 West Baltimore residents.[2] Approximately 2,500 of these unduplicated providers practiced in West Baltimore and the remaining approximately 7,500 providers practiced outside of West Baltimore or even outside of the State of Maryland. Individually these providers billed the Maryland Medicaid Program for anywhere between only one (1) claim to upwards of more than 40,000 claims.

	Providers in West Baltimore	Providers Outside of West Baltimore	Total
Number of Providers Delivering Primary Care Services to West Baltimore Medicaid Enrollees	2,635	7,695	10,330
Unique persons served	66,392	60,737	102,941[3]
Number of Unique Provider-Enrollee pairings*	110,865	103,894	214,759
Number of Primary Care Service Records**	281,184	252,043	533,227

Figure 1: Utilization of primary care services by Medicaid members. 2010 Maryland State Medicaid Data, provided by the Hilltop Institute.

[2] Based on Maryland State Medicaid Data provided by the University of Baltimore's Hilltop Institute. The Hilltop Institute provided a summary analysis, included in the Project Databook as well as a set of summary data files that were used to further illuminate the project's findings.

[3] Unique patients served total is the total number of unique Medicaid patients provided care. Some patients may have seen providers in West Baltimore as well as providers outside West Baltimore. Thus the difference between the sum of 66,392 +60,373=126, 765 and the Total unique patients served (102,941), is the number of patients who saw providers both in West Baltimore and outside West Baltimore (23,824).

Despite this wide dispersion and fragmentation, there is a group of 10-15 core safety net providers, dominated by Federally Qualified Health Centers (FQHC) and practices affiliated with the University of Maryland that are the heart of West Baltimore's safety net and accounted for approximately 40% of all claims billed on behalf of West Baltimore residents. In 2010, the FQHC providers billed for approximately 30% (~ 110,000) of the Medicaid claims; practices affiliated with the University of Maryland accounted for approximately 5% and the remaining 5% were accounted for by a group of other private practice providers for which little is known. [4] In 2010, 38% of the low income residents, those living < 200% of FPL were served by FQHCs.[5]

Ranking	Provider Name	Number of Services records*	Percent of Total (in West Baltimore) Service Records
1	Total Health Care Inc.	45,832	16.30%
2	Family Health Centers of Baltimore	19,335	6.88%
3	Health Care For Homeless	8,807	3.13%
4	Maryland General Hospital	5,717	2.03%
5	Chase Brexton Health Services	5,201	1.85%
6	Chiang, Peter P	4,290	1.53%
7	University Of MD Medical	4,091	1.45%
8	Richardson, Teri R	3,914	1.39%
9	University Of MD Med System	3,069	1.09%
10	University Specialty Hospital	2,927	1.04%
	Totals	**103,183**	**36.70%**
	Total (across all providers in W. Balt.)	**281,184**	**100.00%**

Figure 2: Top providers of primary care services to the Medicaid population in 2010. 2010 Maryland State Medicaid Data, provided by the Hilltop Institute.

[4] Maryland Medicaid Program Data, provided by the Hilltop Institute. See Project Databook for further clarification
[5] Health Resources Services Administration's UDS Mapper Data, which can be accessed at www.UDSmapper.org and is summarized in the Project Databook and the project's associated presentations.

Little is known about the overall quality and continuity of the clinical services provided by solo and group private practitioners that serve low income uninsured and Medicaid insured populations, but it is fair to assume that they provide little to no enabling and supportive services that are often critical to the low income individual and families if they are going to gain access and fully engage needed care. The FQHCs and many of the hospital-based practices that serve the largest portion of West Baltimore residents, on the other hand, typically provide a broad range of enabling and supportive services such as outreach, health education, case management, interpreter services, and transportation. A number of the FQHCs also offer integrated behavioral health, dental, and medical specialty care services. While there remains unmet need, the FQHCs are well supported and take great strides to ensure that care is well coordinated and patient-centered.

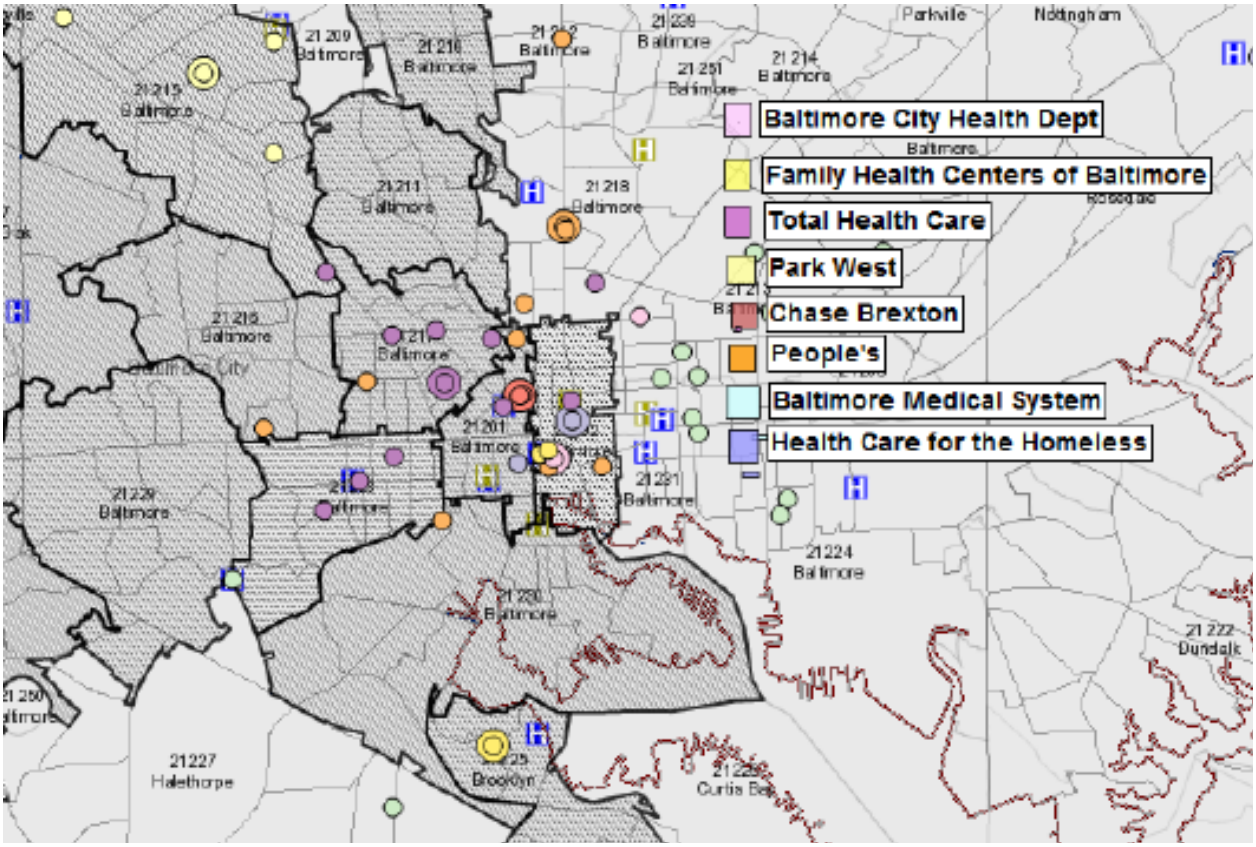


Figure 3: Location of FQHC providers in Baltimore. 2010 UDS Mapper Data (www.udsmapper.org).

- **Strong Pool of Community Hospitals and Academic Medical Centers:** Baltimore has world class hospitals and academic medical centers that provide the full range of emergency, inpatient and outpatient services as well as associated training, academic research, and community-oriented programs. There are 5 hospitals located in the West Baltimore zip codes identified by the

assessment. These hospitals are: Maryland General Hospital, Bon Secours Hospital, Sinai Hospital of Baltimore, Saint Agnes Hospital, and Harbor Hospital. In addition to these 5 hospitals, there are 5 other hospitals located in Baltimore that also serve Baltimore residents. These are: Mercy Medical Center, The Johns Hopkins Hospital, Union Memorial Hospital, Good Samaritan Hospital, and Johns Hopkins Bayview Medical Center.[6]

In addition to outpatient medical specialty care services, these hospital and medical center organizations provide primary care services through their staff-owned and affiliated primary care practices. The project's methods were not set up to capture the exact number or volume of this care but as eluded to above, practices affiliated with the University of Maryland accounted for approximately 5% of the Medicaid Claims made on behalf of West Baltimore residents.

- **Strong Network of Social Service, Faith-based, and other Community-based Organizations**. Key informant interviews reflected on the richness of West Baltimore's social service network and the long history of grassroots involvement in community development activities on behalf of West Baltimore's residents and neighborhoods. Faith-based organizations, community centers, Boys and Girls clubs, and schools are just some of the organizations that are at the core of this network. These organizations are and will continue to be a major asset for the community as safety net providers work to outreach to and engage communities in primary care and other needed health care services.

- **Academic and Workforce Training Resources.** There are numerous universities, colleges, and community colleges throughout Baltimore that provide a broad range of academic opportunities including degrees and training in health-related professions. Many of these academic institutions are within the West Baltimore area. These academic programs provide a rich resource for the community in a variety of ways. Foremost are their contributions to educate and train residents of West Baltimore and beyond. They play a critical role in workforce development. They are also an invaluable resource and provide guidance, expertise, and support (financial and in-kind) to community endeavors. A perfect example is the fact that staff from Morgan State and Coppin state participated on the Steering Committee and in key informant interviews and Coppin State donated the meeting space for all of the steering committee and stakeholder meetings. These institutions also provide student interns and volunteers that are a great service to the community. This helps to feed newly trained workers into the local force.

[6] Baltimore Hospitals. Retrieved April 2012 from http://www.doctorsdig.com/h/baltimore-hospitals-md.htm.

Weaknesses

- ***Limited Primary Care Capacity within West Baltimore:*** Data from the assessment suggest that while there may be adequate capacity across all geographic areas to serve low income Medicaid insured and uninsured residents from West Baltimore, care may not always be readily or ideally accessible. Based on data collected from the area's FQHCs, who provide nearly all of the uncompensated care to uninsured residents, and the State Medicaid Program, only 57% of West Baltimore residents seek care within the West Baltimore zip codes included in our assessment. The remaining 43% of residents seek care outside of West Baltimore in other parts of Baltimore and beyond.

  The JSI project team's analysis of Medicaid claims data provided by Hilltop along with patient demographic data provided by the area's FQHCs, indicates that there are approximately 115,000 low income residents from West Baltimore currently being served by the FQHCs in West Baltimore and the State's other Medicaid Program providers. This data further indicates that there are approximately 115 full time equivalent (FTE) primary care providers (PCP) serving this population and that only 65 FTE PCPs practice within West Baltimore. The other 50 FTE PCPs (43%) practice outside of West Baltimore. For some, seeking care outside West Baltimore may be a function of the fact that they live on the perimeter of what this assessment has defined as West Baltimore and providers are more proximate outside the defined West Baltimore service area. For others, it may be they seek care outside of West Baltimore based on provider preferences, work location, or it may be that they don't find that there is a provider more local that has availability or of the quality they are looking for. Further study would be required to understand this care seeking behavior in a more nuanced way. Furthermore, the data suggests that while there may be adequate capacity to meet current demand for services, there is not enough capacity within West Baltimore or beyond to meet the full need if everyone were to access primary care for non-emergent conditions, and rely less on the emergency room for urgent care. This is likely true now in the current health care policy context but will be certainly true in 2014, if the reforms called for by PPACA are fully implemented.

  Currently, there are large proportions of the population who are uninsured and therefore face significant barriers to access. If PPACA is fully implemented there are two major components of the act that will work to reduce the number of uninsured and increase their access to care. More specifically, PPACA will expand eligibility for Medicaid, requiring all states to increase their eligibility requirements to 133% FPL. PPACA will also institute policies that mandate that all consumers purchase insurance and provide subsidies to those living between 133% and 400% FPL. Based on US Census Bureau data from American Community Survey on the socio-economic characteristics of the those who are currently uninsured, we grossly estimate that an additional 22,606 residents in

West Baltimore will be insured through PPACA's Medicaid Expansion components and that an additional 27,636 patients will be insured through PPACA's Insurance Exchange components. Furthermore, we estimate that if all of these residents were to seek a primary care medical home that West Baltimore would need to build its primary medical home capacity by 32.2 FTE PCPs.

	Est. of Uninsured Eligible for Medicaid Expansion	Est. of Uninsured Eligible for the Exchange	Est. of Uninsured Eligible for New Coverage Under ACA
# additional insured patients	22,606	27,633	50,239
# projected additional claims (~ 3.2 Claims per patient)	72,339	88,426	160,765
# Additional PCP FTEs Required (Estimate of 5K claims / FTE)	14.5	17.7	32.2

Figure 4: Estimated uninsured in West Baltimore eligible for coverage under the Affordable Care Act.

Note: These estimates are based on review of 2010 census data and analysis provided by Hilltop of current Medicaid claims from which an estimate of safety-net provider FTEs was derived. A complete description of this analysis can be found in Appendix C.

This is a gross estimate and assumes that none of these newly insured are currently receiving care through the primary care safety net providers. Thus while this may be a conservative overestimate of additional need capacity, it is clear that incremental growth will need to build over time to meet expanded demand brought on by PPACA.

- **High utilization of the emergency room:** Further reinforcing the argument regarding PCP capacity shortages is the fact that in some West Baltimore zip codes as many as 55% of emergency room visits are related to primary care preventable conditions. These are conditions for which ED care is required at the time of the ED visit but could have been prevented if timely and effective ambulatory care had been previously received in the primary care outpatient setting. Key informant interviewees talked about emergency room utilization as an indicator of access to care as well as being a result of ingrained patterns of care seeking behavior in the community. They described community residents as using the emergency room over primary care for several reasons: 1) perception of high quality 2) immediate access to services 3) inability to attend appointments during regular business hours 4) difficulty maintaining scheduled primary care appointments due to complexity of their lives 5) lower co-pay financial obligation in the ER versus a

doctor visit. All of these factors contribute to some individuals actually choosing the ER over going to a primary care provider for service.

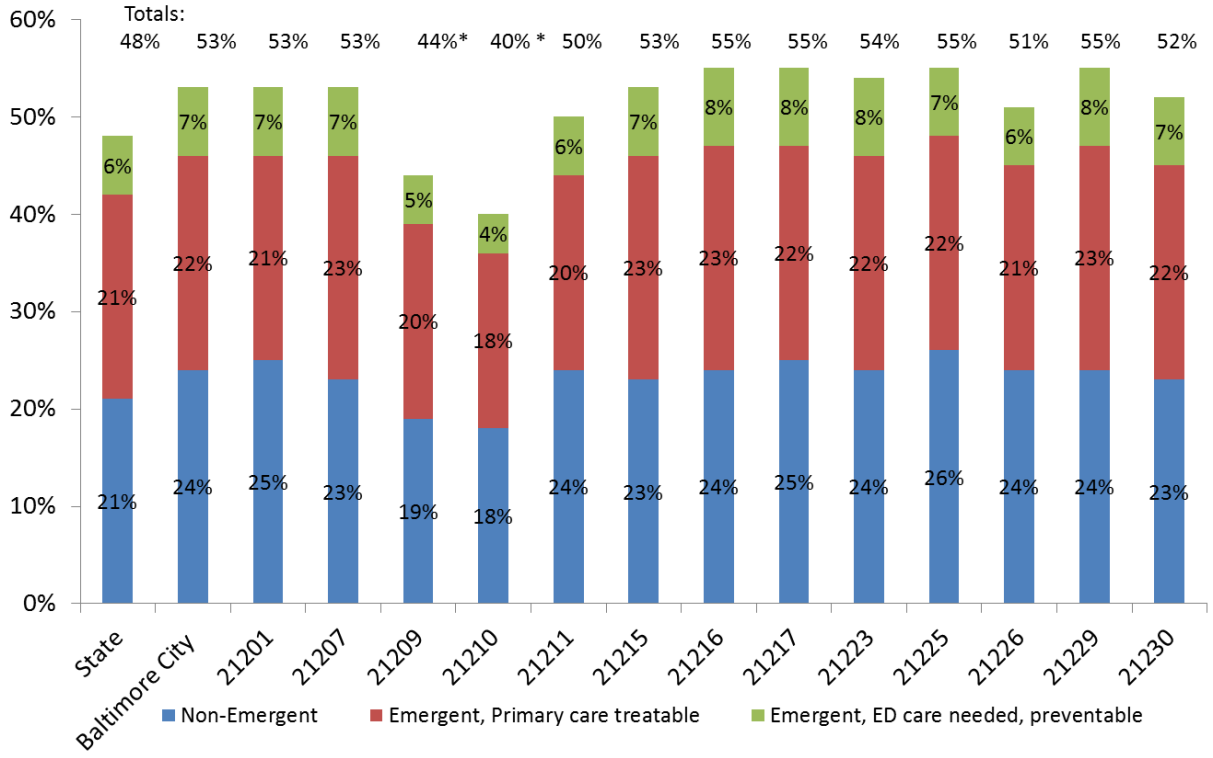


Figure 5: Preventable emergency department visits. Maryland Health Services Cost Review Commission. *Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, 2009-2010*. Inpatient Research Case/Mix File and Non-Confidential Outpatient File provided by the St. Paul Group.

- ***Limited Access to Primary Care After-hours or on Weekends***: While many primary care providers are available in West Baltimore, the majority of them are open during standard business hours. FQHCs do provide some days with extended hours (early morning and/or later evening until 7 or 8pm), as well as some Saturday hours. However, when patients seek services in the evenings or weekends, typically their only option for care is emergency room services. (Appendix D).

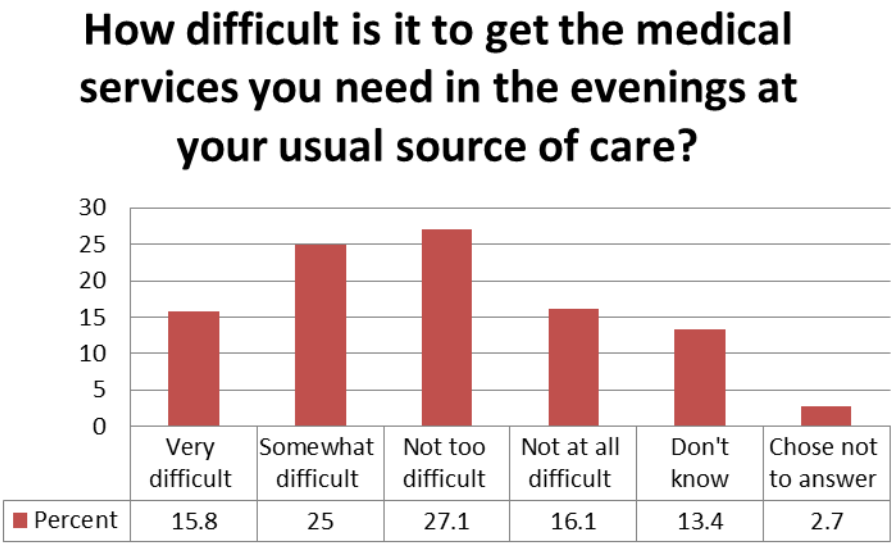


Figure 6: Evening access to primary care in West Baltimore. West Baltimore Primary Care Access Survey. Conducted by JSI in October and November 2011 via convenience sampling of West Baltimore neighborhood residents.

B. BARRIERS TO CARE

- ***Enrollment and maintenance of coverage:*** Expansion of coverage through health reform will enable low-income adults to access insurance through Medicaid and the health exchange. This expansion will provide insurance to many adults who have not been able to access coverage in the past, and thus are unfamiliar with the concept of health insurance and how to use it effectively. One challenge is that for low-income adults, their incomes may fluctuate greatly month to month and year to year thus their eligibility for specific programs also fluctuates. It is important to consider how Medicaid and the Exchange accommodate these fluctuations in income, and whether it is possible to provide continuous and seamless coverage for a population for whom income instability is the norm rather than the exception. Further, the enrollment and re-eligibility assessment process must be made accessible to adults with low literacy. Otherwise, gaps in coverage will occur simply to inability of individuals to enroll and fill out paper work. Outreach and education efforts should be targeted to identify those most likely to be unaware of the new availability of health coverage, and to offer enrollment assistance in an accessible way.

- ***Consumers' cost of care. Fees, co-pays, deductibles too high:*** For insured individuals, the cost of care can continue to be a barrier to access to services. Depending on the coverage type and carrier, consumers may experience "under-insurance" where the deductibles and co-pays are beyond their income and ability to pay. In these cases individuals may delay or avoid needed services due to cost. Continuing assessments of affordability of plans is important, as well as working with

individuals one on one to identify if cost is a barrier and support them in identifying programs that may be able to offer services at a lower cost or sliding fee scale.

- ***Co-pays for an office visit higher than co-pays for emergency room:*** Incentives for where services are accessed historically have not always been aligned with preferred access points of care. In some cases the consumer cost to see a primary care provider is higher than to see an emergency room physician and this provides an economic incentive for consumers to choose emergency room care for primary care sensitive conditions.

- ***Lack of after-hours and weekend care:*** As mentioned above, after hours and weekend care are critical components of comprehensive primary care access. Often services are needed outside of Monday-Friday 9-5, and if these are not available in the primary care setting individuals will access care in the emergency room. Based on our review of the FQHCs hours located in West Baltimore, many FQHCs currently offer some after hours and weekend hours. However, the awareness of the availability of these is not well known among either patients or providers.

- ***Long wait-times for appointments and at primary care sites:*** For acute primary care needs, patients should be able to get an appointment within 24 hours; however, this is not always available. If patients have to wait more than 48 hours for acute needs, they likely will seek care in the emergency room. Based on the community survey 51% patients reported wait times of more than two days for an appointment. Further, if patients are asked to wait for long periods of time in the waiting room for an appointment this also will deter patients from seeking care in the primary care setting.

- ***Complexity of lives inhibits access to care at standard times/Challenging to keep appointments due to complexity and stress in daily lives:*** For many individuals in West Baltimore, health needs are complex, but so are the social and economic circumstances of their live Even with the best intentions, patients may have difficulty keeping appointments due to family obligations, low-wage jobs that do not provide sick leave or time to go to doctor appointments, and transportation barriers. For this reason, services available by appointment only, and that are not easy to access geographically present barriers to care.

C. CARE COORDINATION AND CONTINUITY

- ***Need to ensure that care is more patient-centered:*** "Right care, right place, right time": Providing care in the right place, right time, is wrapped up in the concept of making primary care easily accessible and user friendly. This is especially true for a population that faces challenges in accessing care at traditional appointment times. Too often in West Baltimore primary care is not

open when a patient needs it, and thus the patient loses continuity of care by seeking care in the emergency room in addition to adding costs to the system.

- ***More "customer friendly" approach:*** Key informant interviews identified that one barrier to access is poor customer service. If patients are not made to feel welcomed and cared for in the primary care setting, they may avoid seeking care for this reason as well. As in every other industry, training on providing high quality customer service is required to provide the highest quality of care. A customer friendly approach also involves engaging patients by seeking their feedback on services and service quality and actively addressing patients' concerns.

- ***Service integration/care coordination:*** Many services, such as screening and prevention programs, in West Baltimore are provided which increase access to needed services. However, patients face gaps in connecting these services to ongoing health management, and access to affordable medications. Key informants noted that many patients are not seeking regular care to manage chronic disease or are waiting until their illness is acute. While care coordination is often not a reimbursable service in the primary care setting, it is a critical service to transition patients from hospital to home, and from primary care to specialty settings as well as the many other providers and services.

- ***Care is fragmented due to care seeking behaviors and shopping around for low cost care in segments:*** Patients with low-incomes are the most sensitive to prices in the health care setting, and for this reason may make decisions to see many different providers based on the lowest cost alternative at the moment. Key informant interviewees noted that patients will shop for the lowest price services, and this can lead to accessing care in multiple places and prevent an ongoing relationship with a single provider. This can lead to disjointed services such as free screenings, mammograms, and flu shots that may not then become part of a patient's health record. This can compromise the quality of care the patient receives and has potential to cause harm if information is lost on current medications and conditions across providers.

D. ENGAGEMENT IN PRIMARY CARE

- **Outreach, identification, and screening:** Baltimore has a wealth of outreach, identification, and health education resources including the Breast and Cervical Cancer Screening Program, various HIV/AIDS prevention and screening efforts, Healthy City Days which bring comprehensive health fairs to locals all over the city, dental screening/treatment clinics, immunization clinics, and a myriad of other programs. However, despite these current efforts, there remains a need for more activity in this area. These services are often not reimbursable and thus are paid through grant dollars or cross subsidization from other income streams. As a result, even with the interest among

providers to expand these services, it is financially difficult. That being said, outreach is critical because both the emergency room data and qualitative data indicate that community members are often accessing services when conditions become acute and costly. Linkages across these services can expand their impact through collaborative marketing and outreach and support community members by connecting the data on all of the services they receive.

- **Health education and wellness:** Much of health happens outside the confines of the doctor's office. Individual's daily habits with respect to diet, exercise, and safety have a large impact on their overall health. Similar to outreach and screening, health education and wellness are critical but are not well funded. Baltimore has a wealth of educational institutions which are resources in terms of development of programs as well as research on the most effective programs. These resources should not be underestimated or ignored as important assets to the community with the potential to support overall wellness in West Baltimore.

- **Self-management support:** Chronic disease including hypertension, diabetes, and obesity are significant health concerns for the West Baltimore community. In addition to primary care access, many individuals would benefit by resources to support them in managing chronic disease. This includes education, case management, motivational interviewing, medication assistance and supported referrals to ensure that individuals access care. These services are critical to ensure that patients with chronic disease take the necessary steps to manage and improve their health status. Once again, these types of services are available, but the demand is much greater than what is available and there are certainly even more people with chronic disease that are not currently engaged in care. New payment models for evidenced-based care that focus on chronic disease management and engagement in care such as medical home payments and accountable care organizations which provide global payments have promise to financially support these types of services. Furthermore collaborative efforts across safety net providers should be encouraged to stretch and maximize existing resources.

E. DISPARITIES IN HEALTH STATUS AND HEALTH OUTCOMES

Many of the major health outcomes in Baltimore City have improved gradually over the last decade. Indeed, for all demographic groups within the City, mortality declined significantly between 2000 and 2010 (21% for men, 23% for women, 20% for blacks, and 24% for whites).[7] While health outcomes have improved for all, significant disparities remain between different racial groups. According to the 2010 Baltimore Health Disparities Report Card, Baltimore City fares worse than the rest of the state of

[7] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

Maryland on almost every major health indicator, including heart disease, infant mortality, and asthma.

These disparities are driven largely by differences in residents' access to resources and opportunities that promote and enhance health. Generally speaking, those of higher education and income have greater access to and control over these resources and opportunities, enabling them to live longer healthier lives. They also tend to be more satisfied with their health care. According to our survey, 78% of community residents surveyed with incomes >$50,000 would recommend their doctor, compared to 40% of those with incomes <$25,000.

While some of the largest disparities revealed in the report are between those of differing education or income levels, there are also stark disparities when it comes to race.

According to the report:

- 16% of Black Baltimore residents have diabetes, compared to 8% of White residents,
- 42.3% of Black adults are obese, compared to 20.8% of White adults in Baltimore,
- Infant mortality for Black women is 14.3% compared to 7.3% for White women and;
- 33.5% of Black residents reported unmet health needs compared to 9.1% of White residents.[8]

F. CHRONIC DISEASE

Strengths

- **Collaborative initiatives among West Baltimore FQHCs to address chronic disease related issues:** Three of West Baltimore's FQHCs have developed a chronic disease management program with outside funding that will operate collaboratively to coordinate services to those identified with diabetes, hypertension, and other chronic conditions. This project illustrates the kind of collaborative that is possible and necessary if the safety net is to make significant strides in improving health status.
- **The Baltimore Health Disparities Initiative:** The Baltimore City Health Department's health Disparities Initiative (HDI) was initially launched to address health inequities by reducing the prevalence of chronic diseases including cardiovascular disease, stroke, and diabetes among Baltimore City minority residents though increased access to regular health information and cardiovascular screenings and referrals. The HDI has implemented a number of strategies to do

[8] Ibid

this; they include: disease management by community health workers, health education through faith institutions, barbershop initiatives to provide screening and referrals to minority men, a salt intake reduction taskforce/plan, and smoking cessation and tobacco control programs.

- **Significant work in Baltimore to document and address the issue of food deserts:** Collaborations between the City of Baltimore, local universities, and community organizations are serving to put key policy recommendations in action to make healthy food more affordable and accessible to all Baltimore residents.

- **Increased accessibility to farmer's markets:** In 2010, the Baltimore Food Policy Task Force called for the promotion and expansion of farmer's markets in Baltimore City. The West Baltimore Farmers Market was established in 2010 in an effort to promote preventative health and healthy eating within the West Baltimore food desert. Open every Saturday from June to November, the market is a source of fresh fruits and vegetables and other fresh foods unavailable at most local markets. They have made the taking of SNAP benefits via the acquisition of an EBT machine a priority goal for the 2012 season.

- **Home visiting services to help families improve asthma management:** The Community Asthma Program and Reducing Asthma Disparities programs provide home visits by trained community health workers for Baltimore City children ages 2 to 18 who suffer from moderate to severe asthma. These visits aim to: provide general asthma education, assist in creating asthma action plans with health care providers, ensure access to medication, assist families in reducing exposure to asthma triggers, provide supplies to reduce home-based asthma triggers, establish community-based support networks, and improve communication with medical providers.

- **Cancer screening provided by Baltimore City Health Department:** Baltimore City family planning clinics offer breast, cervical, prostate, and testicular cancer screenings, charging on a sliding fee scale. No one is ever turned away because of their inability to pay.

- **High cancer screening rates among women**: According to the 2010 Maryland Behavioral Risk Factor Surveillance System, 85% of Baltimore women over the age of 18 have had a pap test in the last three years, compared to 86% in the state of Maryland. Eighty-four percent of women over the age of 50 have had a mammogram in the past two years in both Baltimore City and the State of Maryland. The **State of Maryland Breast and Cervical Cancer Screening Program** increases breast and cervical cancer screening levels among underserved low-income women statewide by providing quality screening, follow-up diagnosis, and public and professional education.

- **Minority Outreach and Technical Assistance (MOTA):** The goal of the MOTA program is to lower the disproportionately high cancer rates that exist among underserved minority groups through targeted screenings, education, workshops, and other forms of outreach.

Weaknesses

- **Lack of access to nutritious food sources:** A food desert is "an area where the distance to a supermarket is more than ¼ mile, the median household income is at or below 185% of the federal poverty level, over 40% of households have no vehicle available, and the average Healthy Food Availability index score for supermarkets, convenience and corner stores is low (measured using the Nutrition Environment Measurement Survey." Nearly 1 in 5 people in Baltimore live in a food desert. Twenty-three percent of children aged 0-17 live in a food desert and 26% of Baltimore's African American population lives in a food desert, while only 7% of Baltimore's White population lives in one.[9]

- **High rates of inpatient hospitalization for diabetes, pediatric asthma, and cancer in West Baltimore zip codes:** According to the 2009-2010 Maryland Health Services Cost Review Commission's Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, hospitalization rates for diabetes in West Baltimore are as high as 911/100,000 compared to 240/100,000 in Maryland. Rates for pediatric asthma are as high as 734/100,000 compared to 204/100,000. Rates for cancer were as high as 886/200,000 compared to 608/100,000 in Maryland.

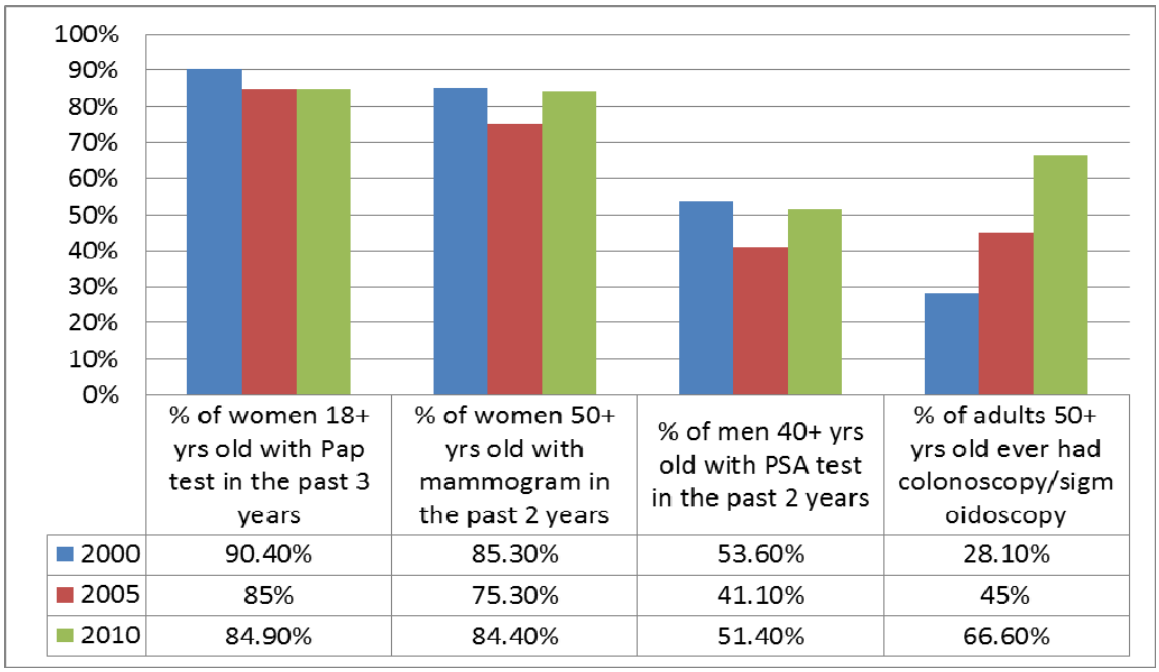
- **Lack of access to medications for chronic conditions**: Cost of medications is prohibitive for the uninsured and underinsured. This leads to lack of compliance with prescribed medications, which may result in deterioration of health and added costs when patients' health declines to the point where they must seek services in the hospital. Many health centers offer medication assistance programs, however these services are likely not known to all that can benefit from them in the community and could benefit by further promotion and outreach.

- **Lack of access to safe and affordable opportunities to exercise:** Exercise is a critical part of health, and communities without easy access to parks, walking trails, gyms and recreation centers face greater challenges in exercising regularly. While an assessment of access to gyms and safe walking areas was not part of the assessment, anecdotally key informants noted that this is an area of need.

[9] Baltimorecity.gov. *Planning/Baltimore Food Policy Initiative/Food Deserts.* Retrieved May 2012 from http://baltimorecity.gov/Government/AgenciesDepartments/Planning/BaltimoreFoodPolicyInitiative/FoodDeserts.aspx.

- **Lack of education and awareness about healthy lifestyles:** Investment in one's health, through healthy behaviors, diet, and exercise requires time, resources, and education. To address many of the chronic diseases identified (obesity, heart disease, diabetes), additional educational resources are needed to support individuals in understanding the impact of these lifestyle choices and support them in behavior change. As noted previously, while there are some programmatic resources available in this area, current funding is not adequate to address the need.

- **Low cancer screening rates for prostate and colon cancer:** According to the 2010 Maryland Behavioral Risk Factor Surveillance System, 51% of Baltimore men over the age of 40 have had a PSA test compared to 58% in Maryland. Only 67% of Baltimore adults over the age of 50 have been screened for colon cancer, compared to 72% in the state of Maryland.



	% of women 18+ yrs old with Pap test in the past 3 years	% of women 50+ yrs old with mammogram in the past 2 years	% of men 40+ yrs old with PSA test in the past 2 years	% of adults 50+ yrs old ever had colonoscopy/sigmoidoscopy
2000	90.40%	85.30%	53.60%	28.10%
2005	85%	75.30%	41.10%	45%
2010	84.90%	84.40%	51.40%	66.60%

Figure 7: Cancer screening rates. Maryland Behavioral Risk Factor Surveillance System (2010).

Statistics

- **Diabetes**
    - 16.3% of black Baltimore residents have diabetes, compared to 8.8% of white residents.[10]
- **Heart Disease**
    - 36% of Baltimore residents have been told they have high blood pressure/hypertension, compared to 29% in Maryland.[11]
    - 41.3% of black Baltimore residents have high blood pressure, compared to 28.6% of white residents.[12]
- **Obesity**
    - Obesity rates among adults have been higher in Baltimore City than in Maryland for the past 10 years.[13]
    - 18.5% of Baltimore children are obese, compared to 12% nationally.[14]
    - 42.3% of black adults in Baltimore city are obese, compared to 28.6% of white adults.[15]
- **Asthma**
    - 510.6/10,000 black children in Baltimore city have asthma, compared to 85.5/10,000 white children.[16]

[10] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

[11] Maryland Behavioral Risk Factor Surveillance System (2010). Retrieved October, 2011 from http://www.marylandbrfss.org/cgi-bin/broker.exe

[12] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

[13] Maryland Behavioral Risk Factor Surveillance System (2010). Retrieved October, 2011 from http://www.marylandbrfss.org/cgi-bin/broker.exe

[14] *Ibid*

[15] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

- **Cancer**
    - The colon cancer mortality rate amongst adults in Baltimore City is 23.9/100,000 for black adults, compared to 16.9/100,000 for white adults.[17]

G. MENTAL HEALTH

Strengths

- **Coordinated system of providers:** The Baltimore Mental Health System (BMHS) is a non-profit agency that serves as the City's local mental health authority or core service agency. In 2009 they served 15,427 children and 26,065 adults. They provide early intervention and oversee a network of predominately private non-profit providers that deliver mental health services to Medicaid and uninsured residents of Baltimore.
- **Increasing availability of integrated services:** FQHCs have some on-site behavioral access. All of the FQHCs which serve West Baltimore have mental health providers on staff. Further, 67% of providers of mental health services (community and hospital-based providers) report that they have taken steps to integrate mental health and substance abuse care. Comprehensive screening for depression improves identification and early intervention to address mental health concerns which impact both mental and physical health.

Weaknesses

- **Inadequate capacity for current needs:** Approximately 28% (based on national prevalence of mental illness and current number served through BMHS) of total population with mental illness receive services through the public providers.
- **Typically mental health screening in primary care is limited to depression:** Mental health includes a spectrum of conditions and needs including trauma, anxiety, bi-polar disorder, and other chronic mental health conditions. Primary care providers need additional training to both identify and collaboratively care for individuals with mental health conditions.

[16] Maryland Health Services Cost Review Commission. *Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, 2009-2010*. Inpatient Research Case/Mix File and Non-Confidential Outpatient File provided by the St. Paul Group.

[17] *Ibid*

- **Separate funding streams make it difficult to provide mental health in the primary care setting:** Billing for mental health services is not always straightforward and there are many restrictions based on the provider license, the payer, and the type of facility where the service is provided. This inhibits access by preventing services from being delivered where the patient may be most likely to utilize them.

Statistics

- 14% of Baltimore adults report 8-30 days of poor mental health in the last 30 days.[18]
- 29% of Baltimore youth reported feeling sad or hopeless almost every day for 2 or more weeks in a row.[19]
- 8.2% of Baltimore youth have attempted suicide.[20]
- Disparity: 33.5% of Black residents reported unmet mental healthcare needs compared to 9.1% White residents.[21]

G. SUBSTANCE ABUSE

Strengths

- **Baltimore Substance Abuse Systems, Inc. (BSAS)**: BSAS serves 23,000 people annually in treatment. To serve this population, BSAS oversees a network of 40 providers operating in 70 locations throughout Baltimore. Services include prevention, intervention, and treatment and recovery programs delivered in outpatient, residential, and medically assisted treatment settings. Accomplishments include:
    - The development and implementation of a Centralized Intake and Referral management Information System (CIRMIS) linking over 60 treatment programs, human service providers, and criminal justice agencies

[18] Maryland Behavioral Risk Factor Surveillance System (2010). Retrieved October, 2011 from http://www.marylandbrfss.org/cgi-bin/broker.exe

[19] Centers for Disease Control and Prevention (2005, 2007). *Baltimore, MD, High School Youth Risk Behavior Survey.* Retrieved January, 2012 from http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=BA

[20] *Ibid*

[21] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

- Integration of primary care within existing substance abuse programs
- The development of a substance abuse education program for primary care physicians administered by the Medical and Chirurgical Faculty of Maryland
- Development of an acupuncture substance abuse treatment program at the Baltimore City Detention Center for male and female offenders
- Coordination of the Maryland One Church - One Addict Project, a state-wide effort to educate faith communities about substance abuse and support services for recovering addicts; and
- Special initiatives including: substance abuse training for Head Start personnel; job readiness training and employment placement for recovering addicts; continuing education for treatment program staff; training on managed health care and provider networks for program directors

- **Buprenorphine Prescription Training for Physicians**: BSAS, in collaboration with local government, the American Society of Addiction Medicine (ASAM), and private industry, is helping to fund a free online training program that will enable eligible physicians in Baltimore City to acquire the a waiver to prescribe Buprenorphine in office-based practices.
- **Open Society Institute:** Open Society Institute provides training and pilots programs for the implementation of buprenorphine at CHCs.
- **The Baltimore City Department of Social Services (BCDSS) Care Coordination and Supported Employment Project**: This project, funded by the Baltimore City Department of Social Services (BCDSS), provides care coordination and evidence-based practice supported employment services to Temporary Assistance for Needy Families (TANF) recipients with a substance abuse disorder. Customers are assigned to Care Coordinators/Employment Specialists, who provide needed supports to empower customers to maintain substance abuse treatment, while obtaining and maintaining competitive employment of their choice. This is provided through strategies that include assertive engagement, motivational interviewing, individualized job development and job supports, integration and coordination with treatment, and community based services.

Weaknesses

- **Unmet Need**: Baltimore City is experiencing substantial unmet need for drug treatment. Each day BSAS receives more calls for help than its present capacity; as a result, persons seeking treatment are often turned away for lack of treatment slots.

- **Funding**: Between 2003 and 2007, funding for drug treatment fell by approximately $10 million
- **Access**: Very limited access to substance abuse screening and treatment in primary care settings

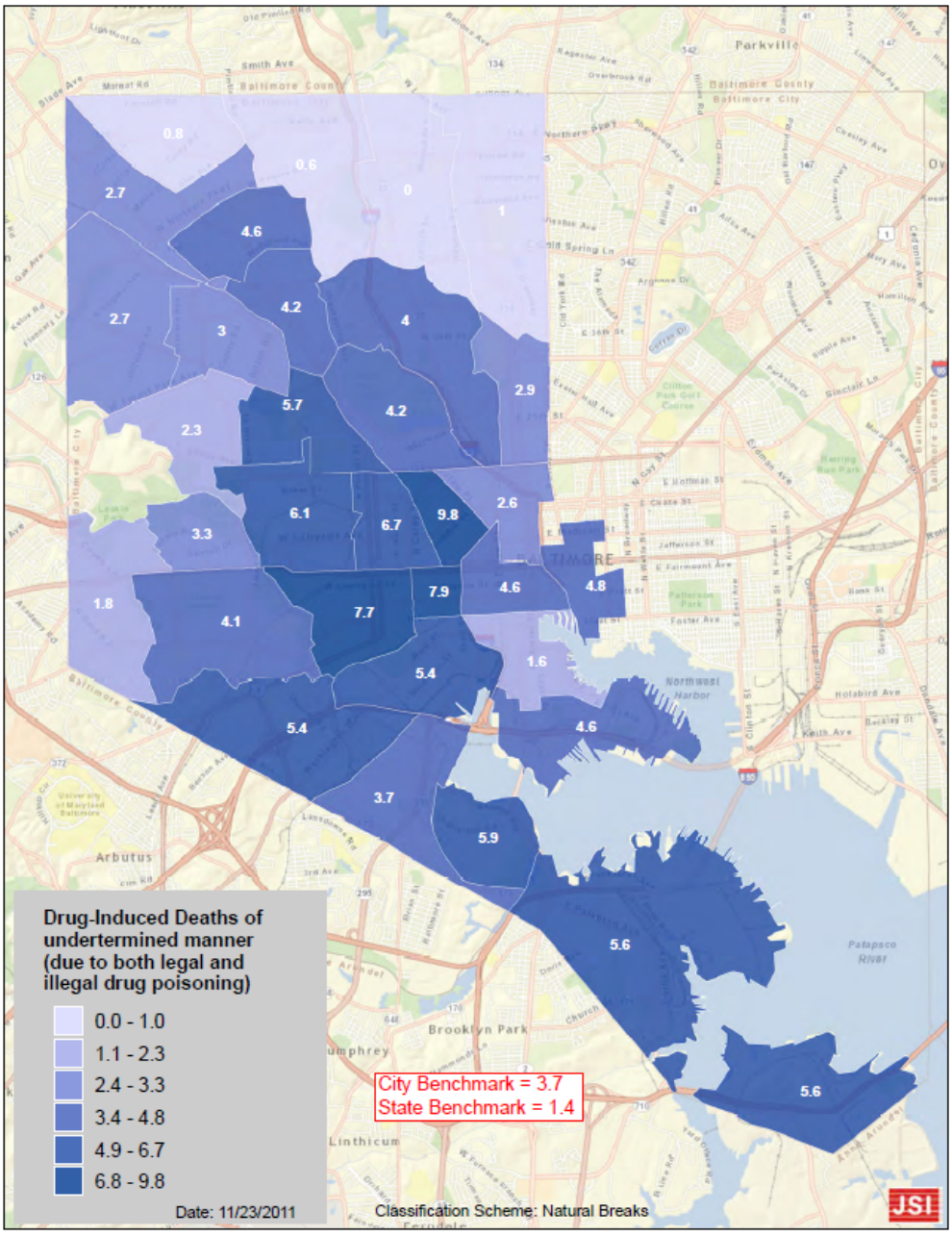


Figure 8: Drug-induced deaths in West Baltimore community statistical areas. Baltimore City Health Department (2010). *Baltimore City Health Department Neighborhood Health Profiles*.

Statistics

- Alcohol and Substance Use ED Discharge rates are as high as 2,761/100,000 in West Baltimore, compared to a state high of 415/100,000. This is more than 6 times higher.[22]
- The highest rate of Alcohol and Substance Abuse related inpatient hospitalization in West Baltimore is 1,062/100,000. The zip codes with the highest rates in the West Baltimore priority area are 21216 and 21225.[23]

H. DENTAL

Strengths

- **Dental Safety Net Providers:** In Baltimore City, dental clinics which provide services to low-income Baltimore residents are available through the local health department, FQHCs, and the University of Maryland Dental School.
- **Special programs to provide outreach:** The Office of Oral Health provides sealants, oral cancer screening, children and adult clinical services and fluoride treatments. The Office of Oral Health offers Dental sealant grants to provide dental services to adults and children in dental clinics and/or school-based/school-linked/mobile settings.

Weaknesses

- **Baltimore residents have poor dental access compared to the state overall**: Compared to State overall, individuals in Baltimore City are:
    - 11.9% less likely to have a dental visit in the past year[24]
    - 12% more likely to have had any permanent teeth extracted[25]
- **Access barriers due to cost:** Cost and insurance are likely the predominate barriers to dental care in West Baltimore, as they are throughout the United States.

[22] Maryland Health Services Cost Review Commission. *Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, 2009-2010*. Inpatient Research Case/Mix File and Non-Confidential Outpatient File provided by the St. Paul Group.

[23] *Ibid*

[24] Maryland Behavioral Risk Factor Surveillance System (2010). Retrieved October, 2011 from http://www.marylandbrfss.org/cgi-bin/broker.exe

[25] *Ibid*

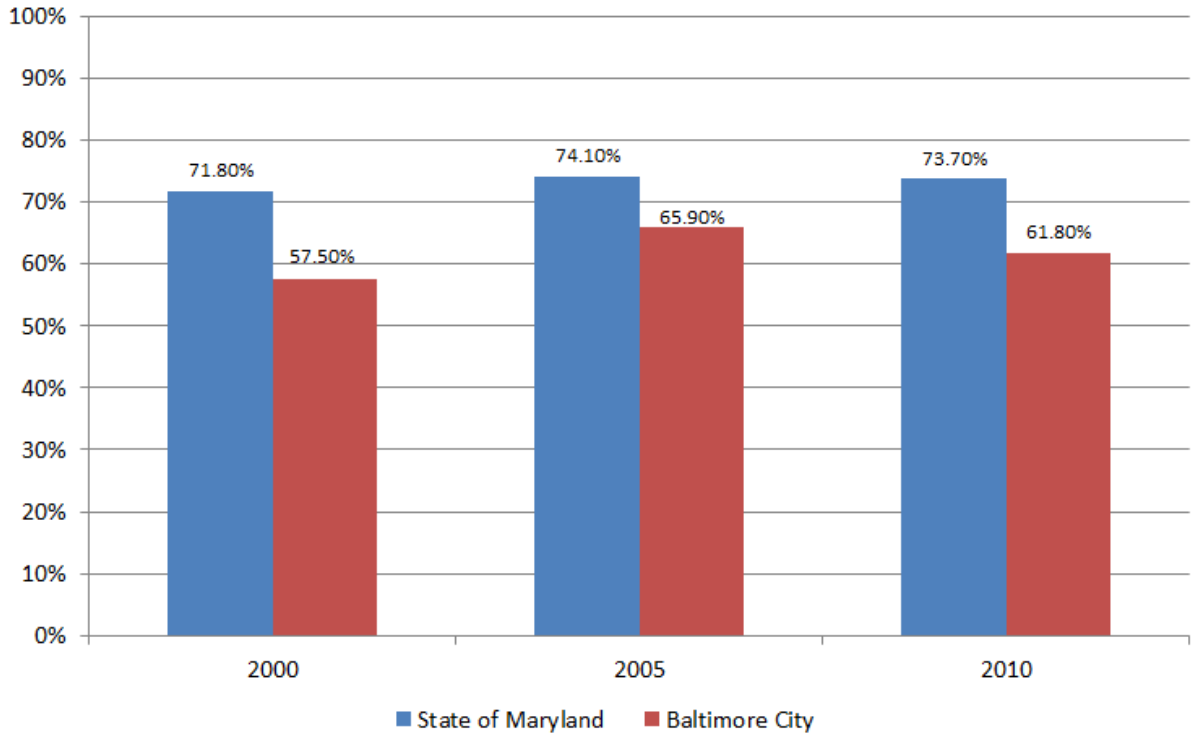


Figure 9. Percent of population who visited a dentist in the last year. Maryland Behavioral Risk Factor Surveillance System (2010).

Statistics

- 61% of Baltimore adults visited the dentist, compared to 73% of adults in Maryland
- 52% of Baltimore adults have had permanent teeth extracted compared to 40% of adults in Maryland

I. MATERNAL AND CHILD HEALTH

Strengths

- ***The Maternal and Child Health Improvement Program (MIHIP):*** The Maternal and Child Health Improvement Program is the single point of entry for identifying Baltimore City's High Risk Pregnant Women and Infants. Community doctors and hospitals identify pregnant women and infants who need case management services such as the Baltimore City Health Department Maternal and Infant Nursing program or home visiting partner program. The goal of MIHIP is to provide comprehensive assessments and education that result in lower infant mortality and morbidity in Baltimore City.

- ***The Baltimore City Health Department Maternal and Infant Care Program:*** The Maternal and Infant (M&I) Care Program provides home visiting and case management services to pregnant women and infants in Baltimore City in order to improve maternal health, birth, and infant outcomes. Services are provided by community health nurses, social workers, and community outreach workers.

- ***Baltimore Healthy Start:*** Baltimore Healthy Start Inc. is committed to reducing infant mortality by utilizing a Life Course Perspective for improving the health and well-being of women and their families though the provision of comprehensive, supportive services offered in the communities where they live. Healthy Start engages pregnant and postpartum women and offers services to increase the likelihood of birthing a full term baby.

Weaknesses

- ***Large Disparities in Infant Mortality Rate:*** The highest infant mortality rate in the West Baltimore priority area is over 2.6 times higher than in the state of Maryland.

- ***Poor Health Indicators:*** Poor health indicators such as poverty, high diabetes rates, high obesity rates, poor nutrition and exercise, and substance use are likely to contribute to poor maternal child health outcomes.

Statistics

- The highest infant mortality rate per 1,000 live births in the West Baltimore priority area is 20.8 compared to a state rate of 7.95.[26]

- 78% of Baltimore women received prenatal care in the first trimester compared to 96% of women in Maryland.[27]

- Infant mortality rates for black women in Baltimore are 14.3% compared to 7.3% for white women.[28]

[26] Maryland Health Services Cost Review Commission. *Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, 2009-2010*. Inpatient Research Case/Mix File and Non-Confidential Outpatient File provided by the St. Paul Group.

[27] The Maryland Department of Health and Mental Hygiene. *Vital Statistics Preliminary Report, 2010.* Retrieved October, 2011 from http://vsa.maryland.gov/doc/prelim10.pdf.

[28] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

- 14.9% of black infants in Baltimore are born low-birth-weight compared to 8.3% of white infants.[29]

J. INFECTIOUS DISEASE

Strengths

- **Baltimore has its own HIV/AIDS Strategy, HIV Health Services Planning Council***:* The Baltimore City HIV/AIDS Strategy (BCHAS) was adapted from the National HIV/AIDS Strategy (NHAS), to address the specific needs, strengths, and challenges Baltimore faces. The target aims of BCHAS are to reduce New HIV Infections, Increase Access to Care and Improve Health Outcomes, Reduce HIV-related Health Disparities, and Achieve a More Coordinated City Response.

- **Health Education Services Provided to Schools and Community Groups upon Request**: Baltimore City Health Department STD Program health educators are available to provide presentations on STDs and HIV. Sexual education in the schools is not a standard offering, and education sessions are at the discretion of the school principal and/or teachers. Several STD staff are faculty of the STD/HIV Prevention Training Center, which provides STD education to hundreds of health care providers each year.

- **Strong Support and Linkages to Care**: The Baltimore City Health Department HIV Care Linkage Program offers care linkage services to quality medical care providers, same-day appointments, referral and transportation services to first appointment, and enrollment incentives to both insured and uninsured clients who are not in care or have fallen out of care for six months or longer.

- **Men's Health Specific Sites**: The Men's Health Center (MHC), operated by Total Health Care, Inc. provides primary care, screening and health education to uninsured males residing in Baltimore City. Based on screening, the center provides referrals to various specialty care services including oral health, STD, podiatry, radiology, cardiology, urology, ophthalmology, substance abuse, and mental health services.

- **Mobile Testing Options:** The Baltimore City Health Department STD Program operates an outreach testing program that provides testing for syphilis and HIV in areas of high morbidity throughout Baltimore City. The outreach staff work out of mobile vans in areas where disease transmission is known to have recently occurred.

[29] *Ibid*

- **Baltimore Needle Exchange Program:** The Baltimore City Needle Exchange Program (NEP) seeks to reduce HIV, hepatitis C, and other infections by reducing the circulation of unclean syringes. The program also helps drug users overcome addiction by linking them to drug treatment services. In addition, the program provides testing for syphilis, HIV, and hepatitis C. NEP is provided in 17 locations in the city of Baltimore.

Weaknesses

- **Large Disparities in HIV/AIDS Mortality Rate between Blacks and Whites, Men and Women**: According to the 2010 Baltimore City Health Disparities Report Card, the HIV/AIDS mortality rate for Black Baltimore residents is 7.7 times the rate for White Baltimore residents. HIV/AIDS Mortality rates among Black males are 7.7 times the rate for White males. The rate for Black women is 9.87 times higher than the rate for White women.

- **Extremely High STI Prevalence in Adolescent Males:** According to a 2010 report from the Johns Hopkins' Bloomberg School of Public Health Center for Adolescent Health, the rate of Chlamydia in men ages 15-19 is three times higher in Baltimore than the state of Maryland. The rate of Gonorrhea among this same group is four times higher in Baltimore than the state of Maryland.

Statistics

- The number of adults <65 who have ever been tested for HIV (not counting tests for blood donations) decreased 8.9% between 2001 and 2010 in Baltimore.[30]

- The HIV/AIDS mortality rate amongst Black residents of Baltimore is 55.8/100,000. The rate for White residents is 7.3/100,000.[31]

- 62% of the zip codes assessed have higher than average HIV/AIDS inpatient hospitalizations.[32]

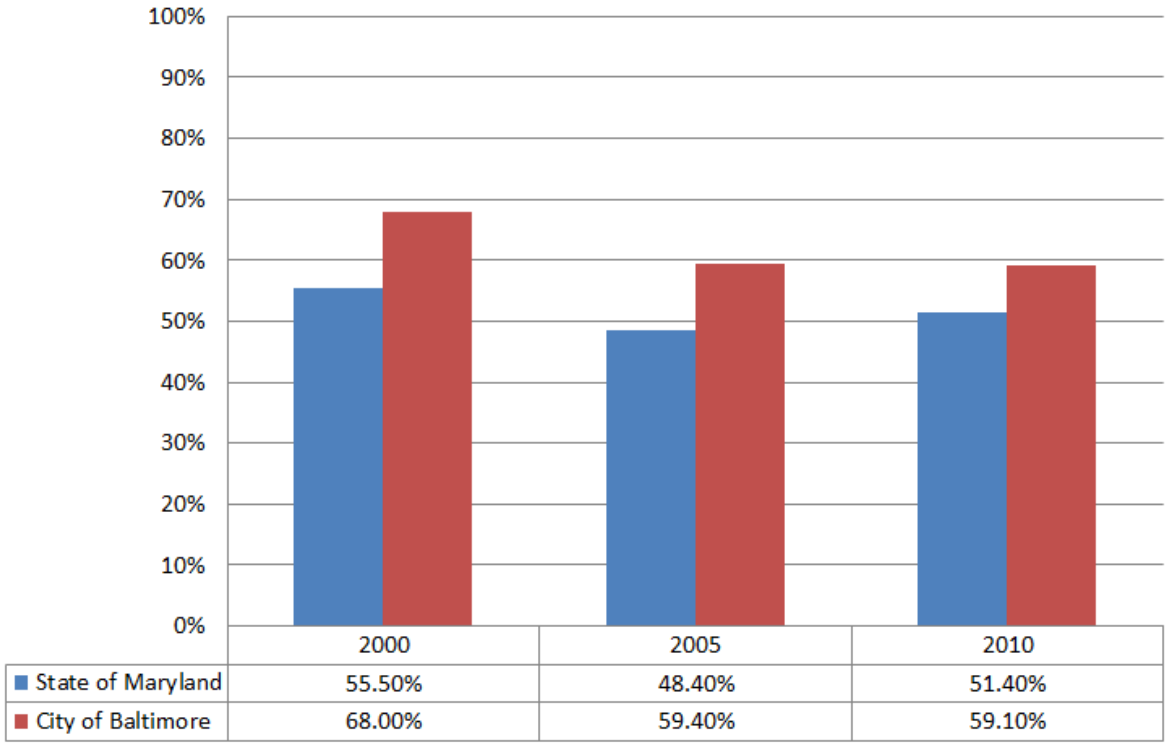
- The rate of Chlamydia among adolescent males (ages 15-19) in Baltimore City is 2,409.3/100,000 compared to 775.3/100,000 in the state of Maryland.[33]

[30] Maryland Behavioral Risk Factor Surveillance System (2010). Retrieved October, 2011 from http://www.marylandbrfss.org/cgi-bin/broker.exe

[31] Baltimore City Health Department, Office of Epidemiology and Planning (2010). *2010 Baltimore City Health Disparities Report Card*. Retrieved October, 2011 from http://baltimorehealth.org/info/2010_05_25_HDR-FINAL.pdf

[32] Maryland Health Services Cost Review Commission. *Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set, 2009-2010*. Inpatient Research Case/Mix File and Non-Confidential Outpatient File provided by the St. Paul Group.

- The rate of Gonorrhea among adolescent males (ages 15-19) in Baltimore City is 1,278.6/100,000 compared to 330.1/100,000 in the state of Maryland.[34]



	2000	2005	2010
State of Maryland	55.50%	48.40%	51.40%
City of Baltimore	68.00%	59.40%	59.10%

Figure 10. Percent of adults under age 65 ever tested for HIV (not counting tests for blood donations). Maryland Behavioral Risk Factor Surveillance System (2010).

[33] Johns Hopkins Bloomberg School of Public Health: Center for Adolescent Health (2010). *Baltimore's Young Men: In Their Prime?*. Retrieved January, 2012 from http://www.jhsph.edu/bin/m/b/MALE%20HEALTH%20BRIEF%20FINAL.pdf

[34] *Ibid*

IV. KEY OUTCOMES AND STAKEHOLDER PROCESS

1. **Leading Community Health Issues Facing West Baltimore Residents.** Based on this systematic review, participants were then asked to identify what they thought were the leading community health issues facing West Baltimore residents. After discussion and deliberation the participants voted using and electronic, automated system that recorded participant votes anonymously for the following three community health priorities:

- **Chronic Disease (33%)**
- **Mental Health (20%) and**
- **Substance Abuse (18%)**

- **Leading Community Health Issues Facing West Baltimore Residents- Ranking by Stakeholder Retreat Participants**

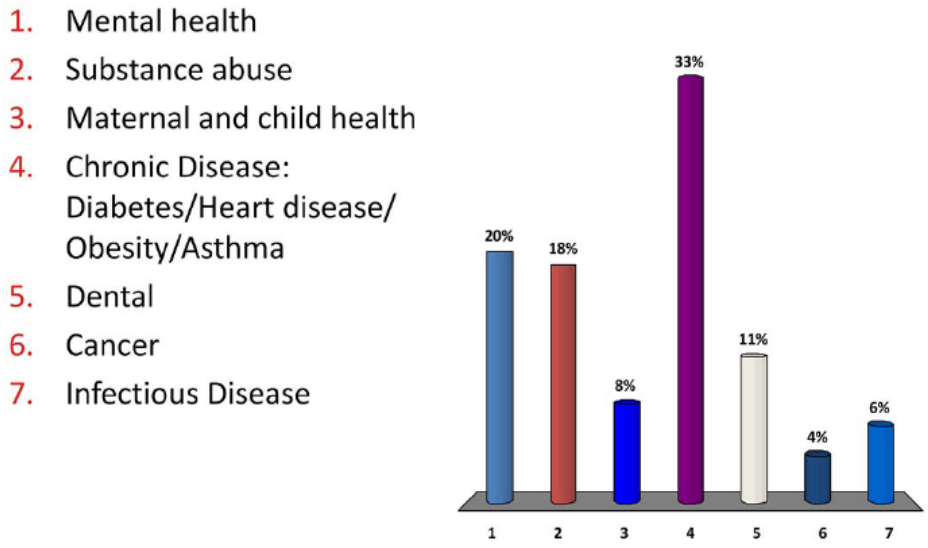


Figure 11. Stakeholder ranking of leading community health issues facing West Baltimore Residents. Stakeholder Retreat Februrary 2012.

There was clear agreement that the safety net should prioritize these health issues and work to reduce the prevalence and incidence of disease and ensure that those with these conditions are identified and engaged in care. In addition, there was also consensus that there were three other over-riding infrastructure development priorities.

2. **Infrastructure Development Priorities**
   - Primary care infrastructure development
   - Patient Engagement
   - Care Coordination and Case Management

More specifically, the participants believed that the stakeholder group needed to make sure that there is adequate capacity of primary care to meet current and future demand. Furthermore, the participants strongly agreed that the safety net needs to address existing health disparities and ensure that everyone receives the highest quality care. Care needs to be taken to foster the incremental growth to meet the expected increased demand from policy changes brought on by health reform/PPACA and outreach efforts. The participants also believed that there were substantial gaps and community need with respect to care coordination and case management. The participants believed that the activities associated with these broad concepts were at the heart of improving engagement in care, reducing the impact of chronic disease, reducing inappropriate ED utilization, and improving health status.

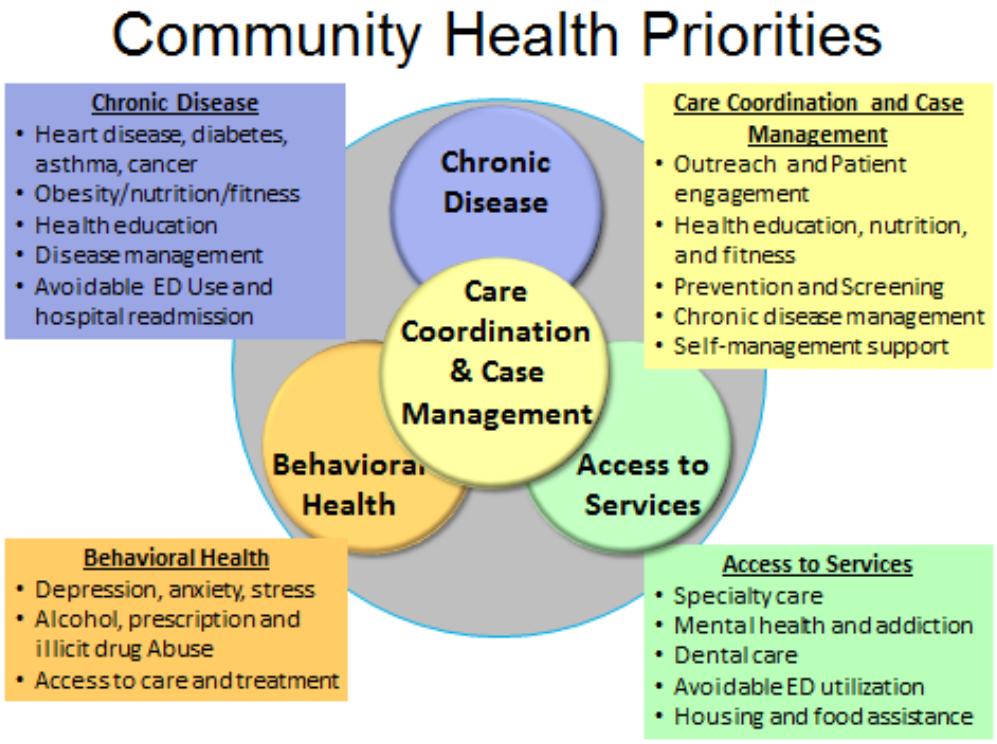


Figure 12. Summary of community health priorities identified during February 2012 Stakeholder Retreat

V. LONG TERM GOALS AND RECOMMENDATIONS

A. LONG TERM GOALS

Based on the findings discussed above, the following are goals that the JSI Project Team believes should guide the West Baltimore safety net stakeholders in their efforts to strengthen, expand, and better meet community health needs of West Baltimore's low income population.

1) **Collaboration and Partnership.** Given current and forecasted economic, public funding, and health care policy trends, collaboration across the primary care safety net will be critical to ensuring access to quality care for the low-income population in West Baltimore. JSI defines a strong primary care safety net network as one that consists of organizations and individuals that are fiscally viable and provide convenient reliable access, assure access to and coordination of comprehensive high quality services, and collaborates to maximize efficiency in the system. A strong health care network does not require that all participating organizations provide the same scope of services in the same way, or to target the same population demographically, socio-economically, or geographically. On the contrary the participants should work together to develop supportive, synergistic programs and policies that ensures viability and strengthens the safety net as a whole.

2) **Expansion of Primary Care Capacity.** Need and demand for services in West Baltimore will continue to require program expansion, particularly in light of Health Reform. Given the uncertainty of health reform and its impact and the inherent resource constraints it is important that organizations move incrementally and cautiously. Organizations should build capacity in an incremental, geographically targeted manner. If new infrastructure (bricks and mortar) are required, efforts should be made to integrate/co-locate services with other types of safety net service providers and/or build smaller community-based clinics in areas of high need or high demand. The core of the safety net should develop in collaboration a multi-faceted approach that leverages all existing resources and opportunities.

3) **Care Coordination and Case/Care Management.** Significant strides have been made by the core of West Baltimore safety net over the past years to strengthen the area's service system for low income residents and promote better engagement in acute care, preventive and chronic disease management services. Despite these efforts there are still large proportions of the population who do not receive the care they need, where they want it, in a timely, appropriate manner. In addition, patients do not often receive appropriate education and guidance that would help them to better understand the steps they need to take to manage their health and promote their overall

well-being. All of these issues would be positively impacted by improved access to and utilization of case and care management and through better care coordination.

4) **Service Integration (vertically and horizontally).** Service integration is a proven, patient-centered, effective, and efficient way to expand access to care, reach out to, and engage those who may not otherwise receive the full breadth of services they may need. When health and social services agencies integrate their services or develop meaningful partnerships there is a much greater chance that patients or prospective patients will receive the full breadth of care they need or at least the information they need to be educated about their health or risk factors. Integration addresses barriers to access, reduces stigma (e.g., mental health, substance abuse, and HIV/AIDS), leads to fewer missed appointments, increases care continuity, and creates a sense on the part of patients that services are responsive to and respectful of their needs.

5) **Medical Home Development**. Changes in state and national policies related to Medicaid/Medicare payment, coverage for the uninsured, service delivery, and other reforms are and will continue to have a major impact on primary care providers, perhaps especially safety net/Medicaid providers, and the way that care is delivered in West Baltimore. Although the specific details and exact impact of the emerging policy reforms are not known, clear preference is being given to primary care practices or clinics that are certified Primary Care Medical Home (PCMH) providers. The State of Maryland is at the forefront of many of these policy reforms and has developed a program called the Maryland Multi-payer Patient Centered Medical Home Program (MMPP) that facilitates enhanced commercial insurance rates for those who are recognized by the National Committee for Quality Assurance (NCQA). Certainly, many health care providers in West Baltimore have already explored and are involved with state programs and/or implementing PCMH principles. Safety net providers in West Baltimore should continue to incorporate PCMH principles into their practices and involve themselves in state and national PCMH efforts both so that they can take advantage of policy and payment reforms and so that they can refine their operations and improve the quality of the care they provide their patients.

6) **Chronic Disease Management.** There is overwhelming evidence that illustrates the disparities in the chronic disease-related outcomes for West Baltimore residents when these indicators are compared to other local, state, and national benchmarks. With this in mind, it is critical that residents have access to the preventive, acute care, and chronic disease management services they need to control and/or prevent these conditions. In order to fully address the health issues and disparities in outcomes that exist in West Baltimore there must be expansive, ongoing, community efforts to address the social determinants of health. This is true with respect to essentially all health issues and priorities that we have identified in this project as one's health is inextricably tied

to one's broader social and community context. This being said, the social determinants of health such as availability of nutritious food, open space for exercise, air quality, housing, income/employment, parenting habits, and other issues are more directly linked to chronic diseases such as asthma, diabetes, and heart disease than are other health issues.

7) **Inappropriate Utilization of Hospital Emergency Departments.** The area's hospitals strive to ensure that West Baltimore residents have access to the broad array of outpatient, inpatient, and emergency services they need to stay healthy and to respond to acute, life threatening health issues. The services they provide through their emergency departments are a vital part of these efforts and are a critical component to the area's safety net. Hospital emergency departments are an important source of both emergent and non-emergent care for West Baltimore residents and are often used as the place of last resort when residents need care and feel like they have exhausted other options. Hospitals also feel a moral and legal obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to provide treatment to patients. This act requires that hospitals provide care to any patient who arrives through its emergency department for treatment, regardless of the patient's citizenship, legal status in the United States or ability to pay for the services. Despite this important role, there is also substantial evidence to suggest that the area's hospital emergency departments are too often used by West Baltimore residents as their primary source for non-emergent medical and behavioral health services. While the services provided through hospital emergency departments are needed and provided in a compassionate and high quality manner, accessing services through emergency departments is often not in the patient's or the hospital's best interest. Using hospital emergency departments for non-emergent issues is typically costly, inefficient and does not promote patient engagement with a comprehensive medical home that proactively engages with their patients to provide regular acute and preventive services, manage chronic health conditions, and coordinate the breadth of services across the care continuum. The area's primary care safety net providers should explore collaborative efforts with the area's hospitals to better link people to medical homes, provide chronic disease management, ensure access to after-hours care, and better coordinate services in an effort to reduce inappropriate Emergency Room utilization and promote patient engagement in primary care medical homes.

B. RECOMMENDATIONS

1) Safety Net Collaboration and Infrastructure Development

The importance and practical benefits of collective and collaborative action across safety net providers, particularly in urban areas like West Baltimore, has never been more critical. Economic issues affecting federal, state and local budgets, trends related to health reform, and the body of literature of best

clinical practices are all moving the health care system to greater and greater levels of collaboration and service integration. Furthermore, the complexity and the fundamental nature of issues that must be considered in order to have sustained impact on overall health status and health outcomes are beyond any one organization or even one type of organization. Often the most effective and sustained responses require a multi-disciplinary, cross-cutting approach involving public and private health, social service, educational and other community-based organizations across the full community continuum.

The fact that this project's stakeholder meetings have been so well attended is testament to the fact that representatives from the core of the safety net understand this, at least at some level. One of the most important outcomes of this project could simply be the commitment on behalf of the core primary care stakeholder organizations to continue to meet. Certainly, there is great diversity across the safety net providers with respect to size, the services they provide, the geographic/demographic target populations they serve, their operational and staffing structures, the way they fund their operations, and even the way they view their purpose, role, and mission. This diversity can make collaboration challenging. What unifies the stakeholders and what could keep organization's at the table is a commitment to serve the area's underserved, low income populations and the understanding that they are vital parts of the area's safety net.

a. Development of the West Baltimore Safety Net Coalition.

Our first recommendation is that the Steering Committee for this project take steps to create a West Baltimore Safety Net Coalition (the Coalition) made up of senior leaders from the organizations that make up the core of West Baltimore's health care safety net. There is significant precedent for this type of coalition throughout the Country and there are numerous success stories that can be drawn on that show the positive impact that they can have in strengthening safety net systems.

As proposed, the Coalition would meet on a regular basis to share information, develop collective communication/advocacy strategies, and explore larger collaborative ideas that might allow them to better meet their individual goals, strengthen the safety net overall, and better serve their target populations. The appeal of this idea is both pragmatic and more idealistic. Pragmatically, experience shows that there is real value in having a regular, predictable forum for core safety net providers to share information and deliberate on programmatic or advocacy-related issues that often benefit from or even require collective action or a common, singular voice. This in itself would provide value and promote collaboration. The Coalition could also be a forum that encourages collaborative projects such as developing referral networks, exploring ways to integrate services, reducing fragmentation or redundancy in services, developing shared service arrangements, developing collaborative ED diversion, chronic disease management or outreach programs, and improving care coordination. This forum would benefit the organizations that are part of the coalition but it would also benefit those

organizations or stakeholders who want to collaborate with the members of the coalition as it would provide a forum for them to share information and propose ideas.

b. Development of Mission/Vision/Core Values Statement.

If the Coalition was established the first step would be to take steps to define the organization's purpose, mission/vision and core values as well as define its initial structure, goals/objectives, and sustainability plan. The following is a draft Mission/Vision Statement and a draft list of core values.

Draft Vision Statement:

The West Baltimore Safety Net Coalition will be a central and driving force to ensure access and improve the health status of all low-income and vulnerable residents of West Baltimore.

Draft Mission Statement:

The mission of the West Baltimore Coalition is to improve access and the health status of all low-income and vulnerable residents of West Baltimore through advocacy, information sharing and collaboration among members of the Coalition and other health care providers serving West Baltimore residents.

Core Values:

- We believe that everyone deserves **high-quality, timely, accessible health care services** regardless of race/ethnicity, income, citizenship status or other demographic or social characteristics.
- We are committed to **ensuring access to comprehensive health care services** for all low-income, vulnerable populations in West Baltimore regardless of race/ethnicity, income, citizenship status or other demographic or social characteristics,
- We are committed to **collaboration and communication** with health and social service agencies across the continuum of care as well as other key public and private stakeholders.
- We strive to develop a **strong, stable, integrated, safety net system** that ensures access to well-coordinated health care services that improve the health and well-being of West Baltimore residents.

2) **Develop Communication & Advocacy Strategy**

The Coalition would also need to develop a communication and advocacy strategy that would allow them to reach out to key stakeholders and target audiences, create an identity, promote credibility, and advocate for issues of common interest. At a very basic level the Coalition could identify coalition members who would agree to participate in existing community forums or standing meetings to discuss collaborative opportunities, advocate on behalf of their agreed upon agenda, and share information back with the group.

3) Access to Care, Expansion of Existing Capacity, and Preparations for the Affordable Care Act

Our findings above highlight the fact that there are major barriers that affect low income population's ability to access quality, accessible, timely primary care services, including preventive care, acute, and more long-term chronic disease management services. It seems clear that many are fully disengaged with the system and go without needed care on a regular basis.

Some of the access issues could be addressed if capacity were expanded in targeted ways, either geographically, with respect to specific types of services (i.e., dental, mental health, or specialized medical services), or for specific segment of the target population by race/ethnicity or age. However, it is also clear that the fact that residents are not getting the care they need has nothing to do with capacity at all and is more a function of barriers to care, lack of health literacy and health education, a misdistribution of existing capacity, and/or a range of underlying social determinants of health (i.e. income/employment, lack of access to nutritious food, poor housing, etc.). Any strategy that addresses the issue of access, health status, and health disparities in West Baltimore needs to be a multi-faceted and incremental one geared to maximizing existing capacity and expanding access in targeted, incremental ways. Perhaps most of all, it will be critical that the strategy promote the development of programs that encourage better engagement in primary care for those who are not accessing care nearly at all, accessing care only sporadically when absolutely necessary, or access care in inefficient ways such as through the hospital emergency department.

The following is a brief review of recommended strategic actions.

a) Maximize benefit from existing primary care safety net capacity

i) **Weekend and Evening Hours for Primary Care Services.** Nearly every data component of our assessment points to the importance of breaking down barriers to access and ensuring that the care that people need is available when and where people need it. With this in mind, it is essential that the core safety net providers make every effort to ensure that preventive, acute care, and, if necessary, chronic disease management services are available after hours on weekends and evenings across the West Baltimore area.

It is equally important that resident, health and social service agencies, and other community-based organizations are aware of when and where this after-hours coverage is available so that that residents can avail themselves of the services and the information can be disseminated as widely as possible. The Coalition could be responsible for creating and disseminating a list of the locations and hours of all sources of after-hours care.

ii) **Service Integration and Collaboration (vertically and horizontally).** As discussed at some length above in the above Long Term Goals section, efforts should be made to encourage and promote vertical and horizontal integration of health and social services. In this regard, health and social service safety net providers such as primary care clinics, hospitals, HIV/AIDS organizations, family planning organizations, dental clinics, senior centers, should explore co-located or enhanced referral approaches that allow them to integrate their services and leverage their collective outreach and engagement efforts.

b) Develop multi-pronged approach to encourage incremental growth in primary care capacity in response to increased demand.

i) **Federally Qualified Health Center Expansion (New Access Points, Expanded Medical Capacity, Mental health, Oral Health, Pharmacy Expansion Grants, and Changes of Scope Requests.** One of West Baltimore's most significant assets is its informal network of FQHCs funded by the Health Resources Services Administration's (HRSA), Bureau of Primary Health Care (BPHC). One of the clear and obvious ways that the safety net could expand capacity is to work with BPHC to expand capacity through various funding opportunities. Although the opportunities are becoming scarcer, BPHC does periodically announce availability of funds to support the development of new access points or expansion of existing capacity either in comprehensive ways that expand the full scope of service or in targeted ways that expand specific services such as mental health or dental services. This strategy clearly presents one of the best ways, if not the best way, to garner financial resources to support those who are uninsured where care is not compensated, as well as to enhance reimbursement rates. Most FQHC organizations receive grants from HRSA ranging from approximately 500,000 to more a few Million per year that support the development and provision of comprehensive services. FQHCs also receive other key benefits such as enhanced Medicaid and Medicare reimbursement, reduced drug costs, malpractice coverage for clinical providers, which provide a tremendous benefit, often far exceeding the benefit from the actual federal grant.

Due to federal budget issues, the availability of funds to expand the FQHC program are becoming more scarce and unreliable but there are opportunities proposed in the pipeline

that could be tapped and the safety net providers should explore these opportunities in targeted ways.

ii) Hospital Outpatient Primary Care Capacity Expansion

West Baltimore's hospitals and the hospitals in the adjacent area also represent a great asset that could be and should be tapped to expand primary care capacity in targeted ways, as long as it does not unduly threaten the viability of other key safety net providers. This would obviously benefit the community at-large by facilitating health care access. It could also work to strengthen these hospital organizations in ways that would allow them to sustain important services and become even more vital assets for the community. Per the data provided above, hospital-based practices provide a significant proportion of primary care access for West Baltimore residents already. Efforts should be taken to explore how hospitals can further expand this capacity in target ways. Critical to this expansion effort is the presumption that existing capacity and new capacity must meet general medical home criteria and provide the full range of well-coordinated, patient-centered services.

Primary care capacity could be expanded in traditional ways by simply expanding clinical capacity at existing sites or by developing or supporting the development of new sites. Hospitals could also develop internal referral mechanisms between their Hospital EDs and their new or existing primary care clinics that would serve to expand capacity and promote engagement in care for those who are utilizing the ED for non-emergent care or care that would be better provided in the primary care setting. Similarly, hospitals could explore the development of Urgent Care Centers or Emergency "Fast Track" clinics associated with the EDs that provide emergent care or primary care to those who present through their EDs. There are practical, legal, and conceptual arguments that complicate this option but it is something that could and should be explored. Once again, it is important to understand that these efforts need to developed with a full understanding of how they might impact other community-based providers but to the extent that they will expand access, promote engagement in care, reduce inappropriate utilization of ED services, and reduce burdens on hospital EDs they should be explored.

iii) Other Targeted Primary Care Expansion Options

Expand the Number of Private Solo or Group Practices that Serve Medicaid-insured residents. Maryland Medicaid claims and utilization data provided by the Hilltop institute showed the large but incredibly diffuse impact that private practice physicians had on access to care for West Baltimore residents. Thousands of private practitioners served only

a handful of Medicaid clients. In the spirit of a multi-pronged approach, efforts should be made to explore how the State Medicaid Program and other West Baltimore community stakeholders can encourage greater participation in the State's Medicaid program. Peer-to-peer efforts, driven by the State Medical Associations, have been shown to be effective at encouraging greater participation. Working to increase payment rates would obviously work, as low payment rates are known to be the most significant barrier to provider participation in the State's Medicaid program.

Retail clinics. Retail clinics, as long as they do not have a detrimental impact on the core members of the existing safety net, could expand access, address access barriers, encourage patient engagement, and reduce costs. Further exploration is needed to refine whether this is a viable and positive option for the safety net to pursue with respect to expanding or improving access to care. However, there is some evidence to suggest that retail clinics when structured to partner with existing provider networks can reduce barriers to care and have a beneficial impact on health access and engagement. Compared with regular health centers, private physician practices, or hospital outpatient clinics, retail clinics tend to serve a population that is younger, more likely to be uninsured or underserved, and less likely to have a regular primary care physician.

Retail clinics are somewhat controversial. Advocates assert that they can provide convenient, low-cost care that expands access with limited to no impact on quality or continuity of care. Opponents assert that the quality of care is not comparable to full-service clinic/practice sites and believe that retail clinics will lead to unforeseen complications, which could result in increased health care costs, poor care coordination, and missed preventive services. In addition, retail clinics could weaken the existing safety net providers if retail clinics developed by outside, large scale chains start to compete with the existing safety net providers.

A number of studies have evaluated the validity of opponent concerns by comparing the cost, quality, and the delivery of preventive services at retail clinics to the care provided at physician offices, urgent care centers, and emergency departments. These studies seem to suggest that the care is comparable or at least not more costly or of lesser quality. It should be noted, however, that the long-term impacts on patient outcomes and/or established primary care provider networks are not well understood, particularly for low income populations and safety net providers. Many of the leading studies have involved commercially insured patients in the general population and the provider networks that serve these general populations.

Retail clinics are a relatively new and emerging model of urgent care. The concept would be to develop small service sites in accessible retail locations that offer a limited range of services such as treatment of minor acute care conditions, chronic disease management follow-up visits, immunizations, and other simple preventive services. These service sites would employ mid-level providers (i.e., nurse practitioners or physician assistants) who provide care on a walk-in basis. Services would be offered at times that were most convenient to community residents, including weekends and evenings, and typically would be provided with short waiting times. Perhaps the idea with the greatest potential would be for these retail clinics to be implemented by, or in close collaboration with, one of the existing primary care safety net providers. This could be done in ways that maximize existing capacity by shifting how staff is currently distributed or could be used to create new service locations.

3. Primary Care Engagement and Chronic Disease Management Initiatives

There is overwhelming evidence that illustrates the disparities in health outcomes that exist for West Baltimore residents when health indicators are compared to state and national benchmarks. With this in mind, it is critical that residents have access to the preventive, acute care, and chronic disease management services they need to maintain their health. Lack of primary care service capacity or lack of capacity where and when people need and want it most is of critical importance. However, as stated above, the lack of demand for services could be more of an issue in West Baltimore than the lack of actual capacity. Those who need services are simply not engaging in or demanding the services they need on a regular and appropriate basis, which is leading to greater morbidity and mortality and greater utilization of hospital emergency and inpatient services.

Collaborative activities need to be taken to promote better engagement in acute care, preventive and chronic disease management services. Ideally these activities involve collaborative efforts that involve organizations that are deeply rooted and connected to the community. (Refer to the Project's Databook for a comprehensive review of some of the more promising national models promoted by the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality (AHRQ)**)**

a. Explore the development of community-based, collaborative projects that promote patient engagement in regular acute and preventive care services as well as chronic disease management programs.

Reaching out to, educating, and engaging community residents in the community-based venues where they live and work has shown to be the most effective way to address barriers and promote appropriate access to care.

i) **Targeted outreach and Education.** Core safety net providers should work with community-based organizations like the Boys and Girls Club, senior centers, and faith-based organizations to develop targeted health education and health promotion events or workshops that reach out to, identify and educate segments of the population on the health issues that have been prioritized by this process.

ii) **Targeted Chronic Disease Management and Primary Care Engagement Programs.** There are a range of best practices that work to reach out to very specific segments of the population who either already have chronic disease or are pre-disposed in order to prevent the disease or to ensure that those who have the disease are; 1) appropriately connected to a primary care provider, and 2) fully engaged in proven chronic disease management programs. Typically, these programs ensure that clients have a regular medical home and provide motivational interviewing and self-management support that teaches them how to live healthier lives, change risky, harmful behaviors, monitor their illness, and cope with their conditions.

iii) **Hospital-based emergency department initiatives that link those who access services through the ED and don't have a primary care medical home with an appropriate medical home.** Hospital EDs play a vital role in the community but too often they are used by community residents as a regular source of primary care. Efforts should be made to encourage those who do access care through the ED inappropriately to become better connected with a true patient-centered medical home that will help to coordinate their care.

iv) **Work with City Health Department, Health Care for All, and other community partners to ensure that those who are Medicaid eligible are enrolled and assigned to a primary care provider.** Baltimore is well recognized for its efforts to assess and enroll those who are eligible for the State's Medicaid program. Multiple organizations have developed streamlined, collaborative efforts that facilitate enrollment and maintenance of coverage. If ACA is fully implemented these efforts will become even more important and more complicated. Those involved in this process should continue their fine work but should also take steps to prepare for the complexity that will emerge with the full implementation of ACA. Efforts should be made to further embed the eligibility and enrollment process within community-based organizations. Stakeholders might find it helpful to reach out to safety

net providers in Massachusetts in order to understand the challenges and opportunities that exist in this regard so that they can develop the most effective programs.

b. Case Management, Care Coordination, and Service Integration

Data from the assessment and information gathered at the stakeholder meetings emphasized the importance of case management and care coordination and the influential role that this broad range of services play in ensuring that 1) those currently engaged in care receive the full range of health and social services they need and 2) that those who are not currently engaged in needed services understand the importance of the services they need and/or are coached in how to address the barriers that prevent them from accessing care. Case management involves a range of services including: 1) assessment and screening; 2) education and health promotion; 3) care coordination and referral management, 4) chronic disease management, 5) and patient engagement. There are many proven ways to provide effective case management and care coordination services with clinical settings, social service settings, and other community settings. Safety net stakeholders should explore ways to build on the case management and care coordination activities. They should also work to deploy case managers, care coordinators, or patient navigators throughout the community that provide very focused support to those with specific conditions or circumstances as well as more generalist case managers that are merely working with residents to assist them to navigate the health and social service system.

VI. CONCLUSION

This assessment has brought together a variety of data sources to paint a picture of the current primary care needs, capacity, and access barriers in West Baltimore. The report and accompanying databook of data resources and presentation slides should serve as a resource for the West Baltimore community to move forward in collaborative work to address the challenges in the community and build a healthier community. There are many assets in the community to draw from to build collaborative efforts including the hospitals, community health centers, universities, and community based organizations. By strengthening the existing programs and building closer linkages across these organizations, there is great potential to maximize the benefit of existing resources and to apply for federal, state, and local funding opportunities to further grow and build innovative programs.

APPENDICES

Appendix A

KEY INFORMANTS AND STAKEHOLDERS

West Baltimore Primary Care Access Assessment: Key Informant Interview List

	Name	Organization
1.	Dr. Anne Bailowitz	Baltimore City Health Department
2.	Ms. Diane Bell McKoy	Associated Black Charities
3.	Dr. Alan Bennett	Park West Medical Systems Inc.
4.	Dr. Robert Blum	Johns Hopkins School of Public Health
5.	Dr. Yvonne Bronner	Morgan State University
6.	Mr. Lawrence Brown	Morgan State University
7.	Brother Art Caliman	Bon Secours Health System, Inc.
8.	Mr. Dennis Cherot	Total Healthcare
9.	Ms. Carmella Coyle	Maryland Hospital Association
10.	Dr. Michael Gibbons	Johns Hopkins Urban Health Institute
11.	Dr. Brian Gibbs	Johns Hopkins School of Medicine
12.	Dr. Michelle Gourdine	Michelle Gourdine and Associates, LLC
13.	Mr. Lewis Hudnell	Community Member
14.	Dr. Usha Jain	Bon Secours Hospital
15.	Mr. George Kleb	Bon Secours Health System
16.	Ms. Amy Kliene	The Harry and Jeanette Weinberg Foundation, Inc.
17.	Dr. Ravi Krishnan	Local Physician
18.	Ms. Faye Larkins	Bon Secours Hospital
19.	Dr. Douglas Mayo	Bon Secours Hospital – Emergency Department
20.	Mr. Miguel McInnis	The Mid-Atlantic Association of Community Health Centers
21.	Delegate Keiffer Mitchell, Jr.	State Leadership
22.	Ms. Dwyan Monroe	Baltimore CHAT
23.	Dr. Allan Noonan	Morgan State University
24.	Dr. Samuel Ross	Bon Secours Hospital
25.	Ms. Suzanne Schlattman	Maryland Citizens' Health Initiative
26.	Secretary Joshua Sharfstein	Department of Health and Mental Hygiene
27.	Mr. John Spearman	University of Maryland Medical System
28.	Ms. Shirley Sutton	St. Agnes Hospital
29.	Ms. Elizabeth Vaidya	Department of Health and Mental Hygiene
30.	Mr. Jay Wolvovsky	Baltimore Medical Systems, Inc.
31.	Ms. Paula McLellan	Family Health Centers
32.	Ms. Pat Cassat	People's Community Health Center

West Baltimore Primary Care Access Assessment: Stakeholders List

Abell Foundation
Associated Black Charities
Baltimore City Community College
Baltimore City Health Department
Baltimore City Public Schools
Baltimore Medical System
Baltimore Medical Systems, Inc.
Baltimore Substance Abuse System
Bon Secours Baltimore
Care First
Carrolton Ridge Community Association
Casey Foundation
Chase Brexton
Coppin State University
Equity Matters
Family Health Centers
Harbour Hospital
Health Resources and Services Administration (HRSA)
Healthcare for the Homeless
Johns Hopkins University
Kaiser Permanente of the Mid-Atlantic
Light Health
Maryland Citizens' Health Initiative
Maryland Health Resources Commission
Maryland Hospital Association
Maryland Primary Care Association
Maryland State Senate
Medchi
Michelle Gourdine & Associates
Morgan State University
Mosaic, Inc.
Park Heights Community Health Alliance
Park West Health System
Peoples Community Health Center
Saint Agnes Hospital
Sinai Hospital
Svwartz, Metz, and Wise, P.A.
The Harriet and Jeanette Weinberg Foundation
The Maryland Center for Behavioral Health
The Maryland Department of Health and Mental Hygiene
The Mid-Atlantic Association of Community Health Centers (MACHC)
The Office of Congressman Cummings
The Open Society Institute of Baltimore
Total HealthCare
University of Maryland Medical Center
University of Maryland Medical Systems

Appendix B

COMMUNITY SURVEY

56682

West Baltimore
Primary Care Access Assessment

Community Survey

John Snow, Inc.

October 2011

56682

PLEASE READ CAREFULLY THE INSTRUCTIONS BELOW AND INFORMATION FOR COMPLETING THE SURVEY.

Thank you for your willingness to complete this important survey.
Your responses to this survey will be very helpful to understand what residents feel with regard to access to health care in their community.

Your responses are completely confidential and your participation is voluntary. Information will never be presented in a way that could identify individual respondents.

- If there is any question that you would prefer not to answer, you can skip over it. However, your response to each question is important to the project.
- If you need assistance filling out the survey due to poor eye sight or difficulty reading, then please ask another person to help you read the survey and respond to each question.

56682

Primary Care Access

1. When you think about your health care in general, how often do you receive the health care YOU need WHEN you need it?

   - O Always
   - O Often
   - O Sometimes
   - O Rarely
   - O Never

2. Was there a time in the last year when you needed medical care but could not get it?

   - O Yes → a. If yes, what was the main reason you could not get services? (Choose only one)
   - O No

     - O Cost (fees, co-payments, deductibles)
     - O No health insurance
     - O Could not find a provider who accepts my insurance
     - O Distance
     - O Office/Clinic was not open when I could get there
     - O Too long a wait for an appointment
     - O Too long a wait in the waiting room
     - O No child care
     - O No transportation
     - O Provider did not speak my language
     - O Don't know
     - O Other: _____

3. When you are sick with a sore throat, where is your preferred place to go for care?(Choose only one)

   - O Doctor's office (specify name: _____)
   - O Community Health Center (specify name: _____)
   - O Hospital (specify name: _____)
   - O Hospital Outpatient Clinic (specify name: _____)
   - O Urgent Care Center (specify name: _____)
   - O Pharmacy Center (specify name: _____)

4. In the last 12 months, how many times did you go to an emergency room to receive medical care?

   O None O 1-2 O 3-4 O 5 or more

56682

5. **Has there been a time in the past two years when you didn't follow your health care provider's advice or treatment plan (including getting a recommended test or seeing a referred provider)?**

O Yes → **a. If yes, why did you not follow the health care provider's advice or treatment plan? (select all that apply)**

O No

- O I didn't understand what I was supposed to do
- O I disagreed with what the provider wanted me to do
- O The provider's advice or treatment plan cost too much
- O The provider's advice or treatment plan was too difficult to do
- O The provider's advice or treatment plan went against my personal beliefs
- O Because of the potential side effects of the drug or treatment
- O I couldn't get an appointment with the referring provider
- O Other _____

b. If cost was a problem, please specify all that apply

- O Medications
- O Follow up visits
- O Procedure
- O Special foods or diet
- O Transportation to appointments

6. **Please respond to each of the following statements by responding strongly agree, agree, disagree or strongly disagree:**

a. I feel comfortable taking time off work to go to the doctors

O Strongly agree O Agree O Disagree O Strongly disagree O Not applicable

b. I believe it is important to my health to go to the doctor for check-ups.

O Strongly agree O Agree O Disagree O Strongly disagree O Not applicable

7. **How would you rate the quality and reputation of the following types of places for medical care?**

	☺ 5=Very good				☹ 1= Poor
a. Community Health Center	O 5	O 4	O 3	O 2	O 1
b. Private Doctor	O 5	O 4	O 3	O 2	O 1
c. Hospital ER	O 5	O 4	O 3	O 2	O 1
d. Hospital outpatient clinic	O 5	O 4	O 3	O 2	O 1
e. Urgent Care Center	O 5	O 4	O 3	O 2	O 1


56682

8. **In the last 12 months have you visited a health care provider (doctor, nurse practitioner or physician assistant) for preventive care? Preventive care visits include things like a check up, routine physical exam, or immunizations.**

O Yes
O No → **a. If No, why not? (Please check the most important reason)**

- O Could not get time off from work
- O Cost (fees, co-payments, deductibles)
- O No health insurance
- O Could not find a provider who accepts my insurance
- O Distance
- O Office/Clinic was not open when I could get there
- O Too long a wait for an appointment
- O Too long a wait in the waiting room
- O No child care
- O No transportation
- O Provider did not speak my language
- O I do not like to go to the doctor unless I am sick
- O Don't know
- O Other: _____

9. **Do you have one person you think of as your personal doctor or primary care provider?**

O Yes O No

10. **Do you have one place (clinic, hospital, practice) that you usually go to for primary care?**

O Yes → **a. If yes, where do you usually go for primary care services?**
O No

- O Doctor's office (specify name: _____)
- O Community Health Center (specify name: _____)
- O Hospital (specify name: _____)
- O Hospital Outpatient Clinic (specify name: _____)
- O Urgent Care Center (specify name: _____)
- O Pharmacy Center (specify name: _____)

11. **How long does it usually take you to get to your doctor from your home?**

O Less than 15 minutes O 16-30 minutes O 31-60 minutes O Over an hour


56682

12. **The last time you were sick or needed medical attention, how quickly could you get an appointment to see a doctor or health professional at your usual place of care?**
    - O On the same day
    - O The next day
    - O In 2-3 days
    - O In 4-5 days
    - O In 6-7 days
    - O After more than a week
    - O Never able to get an appointment
    - O Have not been sick or needed care
    - O Went to an ER

13. **How difficult is it to get the medical services you need in the evenings at your usual source of care?**
    O Very difficult O Somewhat difficult O Not too difficult O Not at all difficult O Don't know

14. **How difficult is it to get the medical services you need on the weekend at your usual source of care?**
    O Very difficult O Somewhat difficult O Not too difficult O Not at all difficult O Don't know

15. **How likely would you be to recommend your doctor to family and friends?**
    O Definitely O To some extent O Not at all

16. **Do you have an active cell phone in your household?**
    - O Yes → a. **Would you be interested in using your cell phone to receive health information or communicate with a health provider? (check all that apply)**
      - O No
      - O Yes, using text messages
      - O Yes, using internet on my phone
      - O Yes, using traditional calls on my phone
    - O No

17. **Do you have any kind of health care coverage for medical care including health insurance, prepaid plans-HMOs or government programs such as Medicaid or Medicare?**
    - O Yes → a. **If yes, what type?**
      - O Medicaid (inlcuding United Healthcare, HealthChoice, Priority Providers, Maryland Physicians Core)
      - O Medicare
      - O Private insurance
      - O More than one type of coverage
      - O Don't know
      - O Other_____
    - O No

56682

Demographics

18. What is your age? ☐☐

19. What is your gender?
O Male O Female

20. Are you Hispanic or Latino?
O Yes O No

21. Which one or more of the following would you say is your race? (check all that apply)
O American Indian or Alaska Native
O Asian
O Black or African-American
O Native Hawaiian or Other Pacific Islander
O White
O Other
O Don't know

22. What zip code do you live in? ☐☐☐☐☐

23. What neighborhood do you live in?
_____

24. How many children (younger than 18 years of age live in your household)? ☐☐

25. How many adults including yourself age 18 or older live in your household? ☐☐

26. Are you a grandparent with dependent grandchildren?
O Yes O No

27. Are you single or married?
O Single O Married

28. Last year, that is 2010, what was your household income from all sources?
O Under $11,000
O $11,001 - $15,000
O $15,001 - $25,000
O $25,001 - $35,000
O $35,001 - $50,000
O $50,001 - $75,000
O $75,000+

Appendix C

HILLTOP MEMO

The Hilltop Institute
analysis to advance the health of vulnerable populations

University of Maryland, Baltimore County
Sondheim Hall, Third Floor
1000 Hilltop Circle
Baltimore, Maryland 21250

phone: 410-455-6854
fax: 410-455-6850
www.hilltopinstitute.org

MEMORANDUM

To: Alec McKinney and Natalie Truesdell
CC: Cynthia Boddie-Willis, Jennifer Smith, and Babi Lamba
From: Ann Chen, Jennifer Smith, Michael Abrams, David Idala
Date: February 9, 2012
Re: West Baltimore Primary Care Services Medicaid Data Request

Introduction

Per a contract with John Snow Incorporated (JSI), The Hilltop Institute is providing four encrypted data sets on Medicaid enrollees residing in West Baltimore region, and on their use of primary care services for calendar year (CY) 2010. Primary care services were identified using Current Procedure Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and UB Revenue codes provider to Hilltop by JSI.

The purposes of this memorandum are to explain the methodology that was used to create the data sets, as well as to offer JSI some guidance regarding their use. Additionally, the memo provides some preliminary summaries of the data as a guide to JSI moving forward.

Methodology

Using Maryland's Medicaid Management Information System (MMIS2), Hilltop identified all such enrollees residing in West Baltimore in CY 2010. The zip code definition of West Baltimore applied (provided by JSI), was as follows: 21201, 21207, 21209, 21210, 21211, 21215, 21216, 21217, 21223, 21225, 21226, 21229 and 21230.

After identifying West Baltimore Medicaid enrollees, Hilltop isolated their corresponding primary care fee-for-services (FFS) claims and managed care organization (MCO) and Primary Adult Care (PAC) program encounters from outpatient, physician, home health, and special services records. Inpatient transactions were not included in order to focus on outpatient care. JSI supplied Hilltop the codes to define primary care services (presented in the first column of Table 1). Per JSI's request, emergency room (ER) claims and encounters were excluded from the analysis based on existing strategies used at Hilltop which are based tightly on HEDIS definitions for emergency department care.

Table 1. Primary Care Services Definition and Exclusion

Primary Care Services (Inclusion criteria- any code enters the observation into the sample)		
CPT	HCPCS	UB Revenue
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99432	T1015	0510-0519, 0520-0529, 0983
Emergency Room Services (*Exclusion*)		
CPT	Place	UB Revenue
99281-99285	23	045X, 0981

To ensure claims and encounters pertain to outpatient services, Hilltop further excluded claims of the following "category of service" or "place" based on coding evident in the MMIS record:

- Category of services: inpatient, hospice, nursing facility, Medicare Crossover – inpatient, and ambulance.
- Places of services: Assisted living facility, inpatient hospital, emergency room – hospital, skilled nursing facility, nursing facility, custodial care facility, hospice, ambulance, ambulance air/water, inpatient psychiatric facility, and comprehensive inpatient rehabilitation facility.

Claims isolated were placed into one of two datasets, the first labeled "institutional" corresponding to UB-40 facility recorded transactions, and the second labeled "medical" corresponding to CMS1500 professional (e.g.,physician, nurse) transactions. Within each of these data sets, the lines of data represented unique "service-records," i.e., a unique encounter between an enrollee and a provider by date of service, primary diagnosis, procedure codes, revenue codes, provider type, provider specialty, category of service, and place.[1] Accordingly, reversals and duplicates have been removed.

The remaining claims thus offer a robust database of all transactions in which a person living in West Baltimore in CY 2010 received a primary care service in that same year. The "medical" and "institutional" datasets are generally to the person-transaction level, and they further include fields that reflect all procedure and revenue codes tide to each claim (even those codes outside of the list per Table 1), as well as codes offering only somewhat standardized record of place and category of service (code details are provided in the a companion data dictionary). A unique provider ID is also yoked to each transaction. In order to isolate the identity of each provider, however, you must merge each transaction to provider records stored in a separate file which affords provider name, address, and a few other fields with additional details such as provider specialty (only sometimes populated).

[1] In there remaining data set transmitter to you, there remain a small number of duplicate records for institutional file is 70 (0.1 percent) and for medical file is 26 (0.005 percent). These seemingly reflect the same persons getting exactly the same set of services on the same day with the same provider; or they could reflect some data entry or processing error.

Summary/Descriptive results

To guide you in your more detailed analysis of the data provided, and because we any ways needed to check the data before transferring it to you, we offer you two simple cross-tab summaries below. Overall, we identified 154,463 Medicaid enrollees in West Baltimore in CY2010- these are all persons in Medicaid in that region, not only those receiveing primary care services.

Table 1 provides aggregated tallies of persons and services divided by the zip code of the provider. These records include data from both institutional and medical files. Row two describes the unique number enrollees with at least one primary care visit. Row three represents the number of unique provider-enrollee pairings. Overall, there were 214,759 unique provider-enrollee records, which include 100,865 transactions that occurred in West Baltimore, and 103,894 that occurred elsewhere. Row four presents the number of total service-records in the data sets (medical and institutional set together). Overall, there are 533,227 service-records, and 281,184 (52.7 percent) of these records were rendered by providers in West Baltimore. Note that in a few instances there appears to be institutional and medical records that isolate the same transactions, presumably because of separate billing for professional and overhead fees.

Table 1. Summary of West Baltimore Primary Care Services CY 2010 Data (Total enrollment= 154,463)

	Provider in West Baltimore	Provider Outside of West Baltimore	Total
Number of Providers Giving Primary Care Services to West Baltimore Medicaid Enrollees	2,635	7,695	10,330
Unique persons served	66,392	60,737	102,941
Number of Unique Provider-Enrollee pairings*	110,865	103,894	214,759
Number of Primary Care Service Records**	281,184	252,043	533,227

*Note the same persons can be served by more than one provider

**This roughly corresponds to primary care service visits, but not perfectly so as some days are broken into multiple records. Subsequent non-duplication by beginning date of service and specific procedure codes will be necessary to sort this out more precisely.

Table 2 shows the number and percentage of primary care service-records for all West Baltimore Medicaid enrollees by the top 10 providers in West Baltimore. These 10 providers delivered roughly 37 percent of all such services.

Table 2. Top 10 Providers in West Baltimore Delivering Primary Care Services to West Baltimore Medicaid Enrollees, CY 2010

Ranking	Provider Name	Number of Services records*	Percent of Total (in West Baltimore) Service Records
1	Total Health Care Inc	45,832	16.30%
2	Family Health Centers Of Baltimore	19,335	6.88%
3	Health Care For Homeless	8,807	3.13%
4	Maryland General Hospital	5,717	2.03%
5	Chase Brexton Health Service	5,201	1.85%
6	Chiang, Peter P	4,290	1.53%
7	University Of MD Medical	4,091	1.45%
8	Richardson, Teri R	3,914	1.39%
9	University Of MD Med System	3,069	1.09%
10	University Specialty Hospital	2,927	1.04%
	Totals	**103,183**	**36.70%**
	Total (across all providers in W. Balt.)	**281,184**	**100.00%**

Caveats

Using the claims and encounters identified by the methods described above, Hilltop isolated all providers that rendered these primary care services (excluder ER and Inpatient). Please note that MMIS data often use group IDs rather than individual doctor IDs to denote providers, but group practices are often not otherwise identified. As a result, the number of individual practitioners does not perfectly reflect the total number delivering primary care services to enrollees in Medicaid.

The institutional and medical files are claims-level data: each line (i.e., service-record) represents at least one primary care service (depending upon the number of procedure and revenue codes included), as defined in Table 1. One record may have more than one primary care procedure or revenue codes, and an enrollee may receive one or more services during a visit. The definition of a visit is: a unique contact between an enrollee and a provider on a given day. To create a visit-level data, the records need to be summarized in some way by *maskid, maskdt,* and *prov*.

Please note that there are seven providers that rendered primary care services but did not appear in the providers address data. This is because MMIS2 does not have address information for these providers. Accordingly, these few observations cannot be geographically sorted.

Finally note that by linking the provider address information to the claims, there are providers who served less than 10 Medicaid recipients. Per HIPAA requirements, we must suppress cells below 11 persons to minimize confidentiality breech risk. JSI is cautioned to be mindful of that

moving forward as well, that is to comply with HIPAA regulations when working with the individual level datasets we are providing.

Datasets Provided

Hilltop is providing four SAS data sets:

1. The file entitled "PC_demog_wBalt_v01" is a person-level data set that contains basic demographic information on all Medicaid persons residing in West Baltimore in CY2010. Medicaid identification numbers have been encrypted for patient protection. (Number of records=154,463, number of fields=4)

2. The file entitled "PC_inst_wBalt_v01" is a claims-level data set that contains all outpatient hospital claims and encounters for the population during the study period. Medicaid identification numbers and date of services have been encrypted. (Number of records=62,827, number of fields=182)

3. The file entitled "PC_medi_wBalt_v01" is a claims-level data set that contains all physician, home health, and special services claims and encounters for the population during the study period. Medicaid identification numbers and date of services have been encrypted. (Number of records=470,407, number of fields=175)

4. The file entitled "PC_prov_addres_v01" is a person-level data set that contains all providers who rendered primary care services to the population during the study period. The variables include provider contact information and provider specialty. (Number of records=10,330, number of fields=11)

5. Hilltop is also providing an Excel file that contains a data dictionary for these files.

Please contact Michael Abrams (410-455-6390) if you have questions about this data.

Appendix D

FQHC TIMES AND LOCATIONS

Baltimore FQHC Clinic Locations & Hours		
Name	**Address**	**Hours**
Baltimore Medical System at Annapolis Road	4000 Annapolis Road Suite 105 Baltimore, MD 21227	M,W,Th,F 8a-5p; Tu 10a-7p
Baltimore Medical System at Middlesex	1245 Eastern Boulevard Baltimore, MD 21221	M,W,Th,F 8a-5p; Tu 10a-7p; Sat 9a-1p
Baltimore Medical System at Orleans Square	2323 Orleans Street Baltimore, MD 21224	Mon-Fri 8a-5p
Baltimore Medical System at St. Agnes	900 S. Caton Avenue Baltimore, MD 21229	Mon-Wed 8a-8p; Th,F 8a-5p
BMS - Belair-Edison Family Health Center	3120 Erdman Avenue Baltimore, MD 21213	Mon 10a-7p; Tu,W,Th,F 8a-5p; Sat 9a-1p
BMS - Highlandtown Healthy Living Center	3700 Fleet Street Suite 200 Baltimore, MD 21224	M,Tu,W,F 8a-5p; Th 10a-7p; Sat 9a-1p
Peoples - Greenmount Avenue Center	3028 Greenmount Avenue Baltimore, 21218	8:30-12:30, 2-5 M-F
Peoples - Maryland Avenue Center	1734 Maryland Avenue Baltimore, 21201	M, W, F, 2-5
Peoples - Washington Boulevard Center	1111 Washington Boulevard Baltimore, 21230	M-F 8:30-12:30, 2-5
Peoples - North Fulton Avenue Center	1300 N. Fulton Avenue Baltimore, 21217	M-F 9-1
Peoples - York Road Center	5225 York Road Baltimore, 21212	T, R, 9-5

Total – Larry Young Division Health Center	1501 Division Street Baltimore, Maryland 21217	Monday, Wednesday and Friday - 8:30 a.m. - 5:00 p.m. Tuesday and Thursday - 8:30 a.m. - 8:00 p.m. Saturday - 10:00 a.m. - 2:00 p.m. (Adult Clinic Only)
Total – Helen Burgess Health Center	Mondawmin Mall 2401 Liberty Heights Avenue, Suite 111-113 Baltimore, Maryland 21215	Monday through Friday 8:30 a.m. - 5:00 p.m
Total – Doris Johnson Medical Center	2400 Kirk Avenue Baltimore, Maryland 21218	Monday, Tuesday, Thursday and Friday - 8:30 a.m. - 5:00 p.m. Wednesday - 11:30 a.m. - 8:00 p.m
Total – Saratoga Health Center	1501 W. Saratoga Street Baltimore, Maryland 21223	Monday through Friday 8:30 a.m. - 5:00 p.m
Total – True Health Center	922 W. North Avenue Baltimore, Maryland 21217	Monday through Thursday - 9:00 a.m. - 5:30 p.m. Friday - 9:00 a.m. - 7:00 p.m
Total – Men's Health Center	Baltimore City Health Department 1515 W. North Avenue Baltimore, Maryland 21217	Monday through Friday 8:30 a.m. - 5:00 p.m
Total - Westside Health Center	2449 W. Frederick Avenue Baltimore, Maryland 21223	Monday through Friday 8:30 a.m. - 5:00 p.m
Total – Linden Health Center	827 Linden Avenue Baltimore, Maryland 21201	Monday through Friday 8:30 a.m. - 5:00 p.m

Total – Washington Village Health Center	700 Washington Boulevard Baltimore, Maryland 21230	Monday through Friday 8:30 a.m. - 5:00 p.m
Park West – Belvedere Site	3319 W. Belvedere Avenue Baltimore, MD 21215	Mon., Tues, Thurs. and Fri. 9:00 a.m. – 5:30 p.m. Wednesday 11:00 a.m. – 7:30 p.m.
Park West – Reisterstown Plaza	4120 Patterson Avenue Baltimore, MD 21215	Mon., Tues, Thurs. and Fri. 9:00 a.m. – 5:30 p.m. Wednesday 11:00 a.m. – 7:30 p.m.
Park West – Sinai Campus	5101 Lanier Avenue Baltimore, MD 21215	Internal Medicine: Mon. – Fri. 8:30 a.m. – 5:30 p.m. Greenspring Pediatric Associates: Mon., Tues., Thurs. & Fri. 8:30 a.m. – 5:30 p.m. OB/GYN Mon. – Fri. 8:30 a.m. – 5:30 p.m
Park West – Men and Family Health Center	4151 Park Heights Ave. Baltimore, MD 21215	Mon, Wed. and Friday 9:00 a.m. – 5:30 p.m
Chase Brexton – Mt. Vernon Center	**Building A - Medical, Case Management, Pharmacy** (NOTE: THIS IS OUR MAILING ADDRESS.) 1001 Cathedral Street Baltimore, MD 21201	http://chasebrexton.org/about_us/hours/#mv

	Building B - Dental, Mental Health, Substance Abuse 10 West Eager Street Baltimore, MD 21201	
Family Health Centers – Cherry Hill	631 Cherry Hill Road Baltimore, MD 21225	Monday through Friday 8:30 AM to 5:00 PM Monday and Thursday, extended hours until 7:00 PM 2nd and 4th Saturday 9:00 AM to 1:00 PM (family medicine and substance abuse services)
Family Health Centers – South Baltimore Family Health Center at Brooklyn	4115 Ritchie Hwy. Baltimore, MD 21225	Monday through Friday, 8:30 am to 5:00 PM
Family Health Centers – Mercy Family Care	315 North Calvert Street, 1st Floor Baltimore, MD 21202	By appointment, including same day: Monday through Friday 8:30 AM to 5:00 PM Evenings and Saturdays by appointment only
Healthcare for the Homeless of Baltimore County	9100 Franklin Square Drive, Suite 204 Baltimore, MD 21237	Monday 10 a.m. – 7 p.m. Tuesday 9 a.m. – 3 p.m. Wednesday 9 a.m. – 5 p.m. Thursday 9 a.m. – 5 p.m. Friday 9 a.m. – 4:30 p.m. Closed from 12:30 – 1:30 p.m. each day Saturday services available for urgent needs only, 9 a.m. to noon, at the Family Health Center at 9101 Franklin Square Drive, Suite 205, 443-777-2000.
Baltimore City Health Dept. – Druid STD Clinic	1515 W. North Ave Baltimore, MD 21217	• Monday: 8:30AM - 5:00PM • Tuesday: 8:30AM - 5:00PM • Wednesday: 8:30AM - 5:00PM • Thursday: 8:30AM - 1:00PM • Friday: 8:30AM - 5:00PM
Baltimore City Health Dept. – Druid Family Planning Clinic	1515 W. North Ave Baltimore, MD 21217	• Monday: 8:30AM – 4:30PM • Tuesday: 10:00AM - 6:00PM • Thursday: 8:30AM – 4:30PM • Friday: 8:30AM - noon

Baltimore City Health Dept. – Healthy Teens and Young Adults	1374 W. North Avenue Baltimore, MD 21217	• Monday: 9:00 AM – 6:00 PM • Tuesday: 9:00 AM – 6:00 PM • Wednesday: 9:00 AM – 6:00 PM • Thursday: 9:00 AM – 6:00 PM • Friday: 9:00 AM – 5:00 PM • Saturday: 12:30 PM - 4:00 PM (during school year only)
Baltimore City Health Dept. – Men's Health Center	1515 W. North Ave Baltimore, MD 21217	• Monday: 8:30AM - 5:00PM • Tuesday: 8:30AM - 5:00PM • Wednesday: 8:30AM - 5:00PM • Thursday: 8:30AM - 5:00PM *only pharmacy and clinic open in the A.M. • Friday: 8:30AM - 5:00PM
Baltimore City Health Department – TB Clinic	620 N. Caroline St Baltimore, MD 21205	• Monday: 8:30 AM - 5:00 PM • Tuesday: 8:30 AM - 5:00 PM • Wednesday: Closed • Thursday: 8:30 AM - 5:00 PM • Friday: Closed
Baltimore City Health Department – Druid Dental Clinic	1515 W. North Ave Baltimore, MD 21217	• Monday: 8:30AM - 4:30PM • Tuesday: 8:30AM - 4:30PM • Wednesday: 8:30AM - 4:30PM • Thursday: 8:30AM - 4:30PM • Friday: 8:30AM - 4:30PM

*Zip codes highlighted in red are those outside of our priority area

Appendix E

STAKEHOLDER MEETING PROCESS

A. Preliminary Assessment and Progress Report

- ***Purpose, Goals of Meeting, and Participants.*** At the culmination of Phase I, the JSI Project Team convened the project's Steering Committee Meeting to update the group on progress-to-date, present its initial findings, begin to explore the impacts and implications of PPACA, and begin to frame the possible strategic responses. Full presentation slides are available in the databook.
- ***Key Discussion Items and Outcomes***
  - *Progress-to-Date:* At the time of the presentation, the Project Team had completed most of its review of secondary data, conducted all of the key informant interviews, and begun to explore the impacts/implications of PPACA. The Project Team also had created the community survey and had begun to collect data from consumers in the community.
  - *Presentation of Key Findings.* The bulk of the meeting was meeting was spent reviewing secondary data an key informant interview findings related to population characteristics, health status issues, barriers to care, and overall strengths/weaknesses of West Baltimore's safety net. The Project Team also reviewed findings related to the impacts and implications of PPACA.
  - *Review of Next Steps for Phase II:* JSI confirmed remaining data tasks, including completion of community survey data collection and Medicaid data collection and analysis. The group discussed how the project team would develop snapshots of a range of possible evidence-based programs that could be applied to address emerging health related issues.
  - Agreed to schedule the first Stakeholder Retreat for late-January or early-February and confirmed participant list as well as the purpose, goals, and general content of Stakeholder Retreat presentation.
  - Confirmed that the data collection and analysis efforts were on track and discussed details regarding the Medicaid data analysis and the community survey process.

B. Initial Stakeholder Group Retreat

- ***Purpose, Goals of Meeting, and Participants.*** At the culmination of Phase II, the Steering Committee convened the first of two Stakeholder Retreats. The purpose of the first retreat was to: 1) Review JSI's charge and workplan,2) Review underlying community context (i.e., demographic/socio-economic population characteristics, health status needs, and barriers to access, as well as strengths/weaknesses of West Baltimore safety net), 2) Review new data related to primary care access and safety net capacity in West Baltimore, 3) Review emerging ideas and the corresponding range of potential strategic /programmatic responses, and 4) discuss next steps and how to promote collaboration across the safety net. (Full presentation is available "Stakeholder Retreat presentation 12/2011" in the Project Databook)

- ***Key Discussion Items and Outcomes***

  Please note that the following is not a summary of the presentation but rather a review of selected key discussion items/comments made by the retreat participants. Please refer to the presentation in the appendix for a review of the presentation's content.
  - Agreed that there should be greater emphasis on mental health and substance abuse and discussed where Project Team could compile additional data and information.

- Discussion of some of the current collaborative efforts such as joint applications for grants to support care coordination

C. Final Stakeholder Group Retreat

- ***Purpose, Goals of Meeting, and Participants.*** In Phase III, JSI analyzed State Medicaid data received from the Hilltop Institute and completed a final integrated analysis of all of the quantitative and qualitative data compiled over the course of the assessment. The JSI Project Team then developed a summary presentation that provided a brief review of all of the project's findings by topic area. Based on this systematic review, participants were then asked to identify and rank what they thought the leading community health issues were for West Baltimore residents. See Project Databook for full presentation slides "Stakeholder Retreat Presentation 2/12/12".
- ***Key Discussion Items and Outcomes***

  Please note that the following is not a summary of the presentation but rather a review of key discussion items/comments made by the retreat participants.
  - ***Opening Remarks and Background.*** Dr. Ross, President/CEO of Bon Secours Hospital located in West Baltimore opened meeting with a quote: "The challenge is not getting the new ideas in, it is taking the old ideas out!". He challenged participants to seize the moment and work to facilitate real action on behalf of West Baltimore resident.

    Dr. Reece(Albert Reece, MD, PhD, chair of the disparities work group and dean of the University of Maryland School of Medicine) discussed his work with the Governor's Quality and Cost Council, and the subcommittee on Health Disparities and the progress in legislation to create Health Enterprise Zones[35].

	Higher Rates		Lower Rates		State
	Zipcodes	Highest Rate	Zipcodes	Lowest Rate	
Emergent (Primary Care Treatable) ED Discharge (%)	21216, 21217, 21226, 21229	55%	21209, 21210	40.8%	48.4%
Alcohol and Substance Use ED Discharge Rate	21217, 21223	1,062	21209, 21210	40	107
Diabetes Hospitalization Rate	21217, 21223	10,340	21209, 21210	1,146	3,488
Pediatric Asthma Hospitalization Rate	21216, 21225	2,131	21209, 21210	184	552

* All rates out of 100,000 population

Geographic target populations for different health indicators (Hospital Dataset)

- ***Review and Discussion of Leading Health Care Issues Facing Community.*** The JSI Project Team provided a brief review of the project's data related to safety net capacity and strength as well

[35] Health Enterprise Zones, as proposed in Senate Bill 234, would receive certain benefits, including grants; authorizing certain nonprofit community-based organizations or local government agencies to received grants; establishing a Health Enterprise Zone Reserve Fund. http://mlis.state.md.us/2012rs/bills/sb/sb0234t.pdf Access on 6/4/2012

as the project's data related to health status and community health needs. The following are selected comments from participants based on the JSI presentation.

Primary Care Capacity	
Strengths	**Weaknesses**
• Medical homes: Urban Heart, Health Equity Population • Integrated behavioral health at FQHCs and CPCP program • HIV prevention (*losing funding, especially at grassroots level) • Communication easily communicated	• Decreasing number of family medicine doctors being trained • Lack of access to specialty care • Lack of financial resources and workforce to address chronic disease comprehensively • Need for data consolidation across providers • Social support network lacking for transitions of care and referrals for ancillary services • Underfunding of tobacco cessation and prevention • Low access to cancer treatment and peer advocacy
Recommendations	
• We should look at EHRs and how they can support transitions in care • We should place special attention on the needs of the senior population and their increasing risks • Patients should be better engaged in and more accountable for their own care • There needs to be improved access to transitional housing and nutritional supplements	

HIV	
Strengths	**Weaknesses**
• FQHCs provide coordinated services	• Short-lived funding • Difficult to apply for Ryan White Funding • Stigma around HIV continues
Recommendations	
• Increased ongoing education • More resources devoted to prevention	

Mental Health	
Strengths	**Weaknesses**
	• Lack of streamlined funding for mental health • No coordinated mental health system integrated with primary care • High demand for psychiatry • Poor tracking services and service provision
Recommendations	
• The intersection of behavioral health (MH/SU) and chronic disease must be addressed • We need a policy of mental wellness rather than mental health treatment	

Dental	
Strengths	**Weaknesses**
	• Dental specialties (i.e. orthodontics) are a large gap for access to dental services • Adult access to dental is extremely difficult • Families and schools don't know that kids are eligible to receive dental services • High no-show rate for dental
Recommendations	
▪ Families need more education about dental health and dental services available to them	

Maternal and Child Health	
Strengths	**Weaknesses**
• Child immunization rate is very high (as high as 99% according to health department)	• Low adult immunization rates • Late entry into prenatal care is high
Recommendations	
▪ More education on MCH issues including importance of early prenatal care, nutrition, and domestic violence	